



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

North Carolina's Medicaid Quality
Measurement Technical
Specifications Manual for Standard
Plans and Behavioral Health
Intellectual/Developmental Disability
Tailored Plans
Version 1.3

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I. Introduction

The North Carolina Department of Health and Human Services (the Department or DHHS) is dedicated to operating a comprehensive Medicaid managed care program that optimizes health and well-being for all North Carolinians. Central to this effort is a commitment to the delivery of high-quality health care through the development of data-driven, outcomes-based, continuous quality improvement process that focuses on rigorous measurement against relevant benchmarks, and appropriately rewards Standard Plans, Behavioral Health and Intellectual/Developmental Disability (Behavioral Health I/DD) Tailored Plans Behavioral Health and providers for advancing quality goals. This document provides an overview of the Department's approach to quality improvement, with a specific focus on quality measurement and reporting and incentives for improved quality performance. The document includes:

1. The Department's vision for advancing quality through Standard Plans and Behavioral Health I/DD Tailored Plans.
2. Detailed information about how the Department will measure plan quality and promote quality improvement.
3. Appendices containing technical specifications for all quality measures that Standard Plans and Behavioral Health I/DD Tailored Plans are required to report as well as those that the Department will calculate.

This document will be updated annually and on an as-needed basis to reflect changes in the quality improvement and measurement approach, including updates to measure requirements.¹

II. Vision for Advancing Quality Through Managed Care

As noted in the Quality Strategy, the Department seeks to develop a data-driven, outcomes-based continuous quality improvement process that rewards Standard Plans and Behavioral Health I/DD Tailored Plans for advancing quality outcomes in targeted areas that support three central Aims: 1) Better Care Delivery; 2) Healthier People, Healthier Communities; and 3) Smarter Spending. Goals and Objectives are tied to each of these Aims, along with a series of interventions, including Advanced Medical Homes (AMHs), Behavioral Health I/DD Tailored Plan Care Management and Healthy Opportunities Pilots outlined in more detail in previous papers and specifically designed to improve quality outcomes in North Carolina.

The Department is committed to rewarding Standard Plans and Behavioral Health I/DD Tailored Plans that accurately report and demonstrate meaningful improvement against specified quality benchmarks. Working with Standard Plans and Behavioral Health I/DD Tailored Plans, the Department will collect a robust set of quality data, which will paint a clear picture of service delivery and clinical care at a statewide and, eventually, a regional level and across demographic measures,

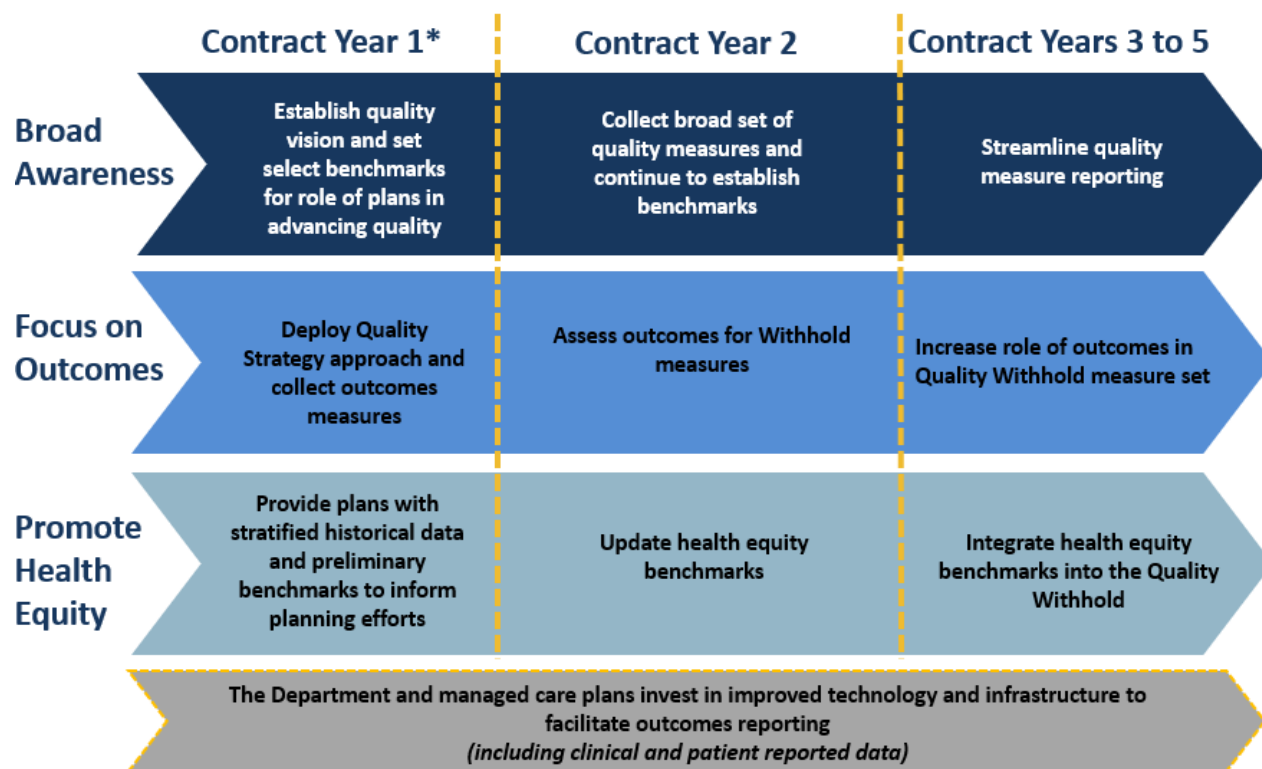
¹ The Department will re-release an update to incorporate Specialized Foster Care Plan requirements in late 2021.

such as age, gender, disability status, race and ethnicity (see Table 1 for the full list). The Department will require Standard Plans and Behavioral Health I/DD Tailored Plans to quickly establish working relationships with providers and other community stakeholders to support accurate plan- and provider- level reporting for quality measures, including selected clinical outcomes. Later years will build on these relationships to both attain increasingly ambitious quality withhold targets focused on priority outcomes specified by the Department (Figures 1 and 3) and include financial accountability for Standard Plans and Behavioral Health I/DD Tailored Plans to improve those outcomes. The Department will also collect and report on select public health measures to link plan quality improvement efforts to larger state public health initiatives and goals.

The Department will support this vision through investments in initiatives to improve outcomes (e.g., through the Healthy Opportunities Pilots and other separate efforts to address upstream social drivers of health and advancement of required infrastructure to facilitate public reporting of quality performance and assessment of state-level health improvements that result from improved care in the NC Medicaid program.

The Department will also expand its role in calculating certain quality measures directly, to limit reporting burden on plans. In turn, the Department expects Standard Plans and Behavioral Health I/DD Tailored Plans to establish the staffing plans, tools, Information Technology (IT) infrastructure and analytic capabilities required to measure quality performance, embed continuous quality improvement efforts to improve outcomes, and possess the capabilities to execute successful strategies to promote health equity. Recognizing the substantial investments Standard Plans and Behavioral Health I/DD Tailored Plans must make to meet quality reporting requirements, the Department intends to invest in improved technology and infrastructure to support plan reporting and will further streamline reporting requirements when feasible, based on the results of reporting in the early years of NC Medicaid Managed Care implementation.

Figure 1: The Quality Vision Over Time



*Refers to the Contract Year for Standard Plans and BH I/DD Tailored Plans, respectively, recognizing their different launch dates. Each Contract Year will run from July 1 to June 30. Quality Performance will be measured as specified in Figure 3: Timelines for Quality Measurement and Contracting.

Over time, Standard Plans and Behavioral Health I/DD Tailored Plans should plan for an increasing proportion of provider contracts to be in advanced payment models that may require alternative approaches to contracting, data sharing, and provider and enrollee engagement. These contracts will drive accountability for quality outcomes, not just at a state level but also at a regional level and extending across populations.

Programmatic Requirements for Quality Improvement

The Department will use a variety of programmatic requirements to ensure Standard Plans and Behavioral Health I/DD Tailored Plans move toward plan-level accountability for health outcomes, and will offer resources to support Standard Plans and Behavioral Health I/DD Tailored Plans and providers in their quality improvement efforts. Most directly, the Department will set goals for plan quality improvement efforts through the establishment of **quality measure sets**, which Standard Plans and Behavioral Health I/DD Tailored Plans will be required to report on, and calculation of historical rates, performance benchmarks and, over time, withhold targets for these measures.

The Department will also share historical rates and performance benchmarks for the measures that will be reported by the Department directly. These requirements are likely to be a major focus of plan efforts, and through the **quality withhold program** (described in greater detail in Section V),

will give Standard Plans and Behavioral Health I/DD Tailored Plans direct financial accountability for a subset of overall quality performance improvement and reduction or elimination of disparities.

The Department will require additional program elements related to quality improvement, including the following:

- The Department expects Standard Plans and Behavioral Health I/DD Tailored Plans to work with their contracting providers to improve quality through Performance Improvement Projects (PIPs), for which the Department will provide broad guidelines. Standard Plans and Behavioral Health I/DD Tailored Plans will submit an annual Quality Assessment and Performance Improvement (QAPI) plan, delineating their plans for PIPs and other quality improvement efforts.
- The Department requires Standard Plans and Behavioral Health I/DD Tailored Plans to engage with external entities to improve quality, including through an accrediting body that will assess quality management processes and offer additional guidance and an External Quality Review Organization (EQRO) that will validate quality performance, assess quality improvement efforts and provide feedback to Standard Plans and Behavioral Health I/DD Tailored Plans, including a separate report on health equity.
- The Department has established requirements for plan deployment of Value-based Payments (VBP) and PIPs to incentivize quality improvement among contracting providers.
- The Department expects Standard Plans and Behavioral Health I/DD Tailored Plans, contracting providers, enrollees and other community stakeholders to share feedback on quality improvement through the Medical Care Advisory Committee (MCAC) and the state Consumer and Family Advisory Committee (CFAC) and offer suggestions that can lead to better processes and outcomes.

Many of these elements have been described in detail in other documents. Further information regarding VBP can be found here. Further information regarding PIPs and QAPI plans, as well as additional details on the EQRO and accreditation, is provided in the accompanying Quality Strategy.

The remainder of this document focuses on quality measure reporting, the Department's use of these measures to assess plan performance, and Standard Plans and Behavioral Health I/DD Tailored Plans use of these measures in their respective contracts with primary care practices (e.g., AMHs) and organizations that provide Tailored Care Management (e.g., certified AMH practices (called AMH+s), care management agencies (CMAs)).²

III. Quality Measurement and Improvement

To ensure that all NC Medicaid Managed Care beneficiaries receive high-quality care, Standard Plans and Behavioral Health I/DD Tailored Plans will be expected to report on, and ultimately be held accountable, for performance against measures aligned to a range of specific goals and

² More information on Behavioral Health I/DD Tailored Plans and Behavioral Health I/DD Tailored Care Management can be found at <https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/behavioral-health-idd-tailored-plan>.

objectives used to drive quality improvement and operational excellence. The Department's use of specific quality requirements to advance toward these goals and objectives will evolve as Standard Plans, Behavioral Health I/DD Tailored Plans and providers' infrastructure and experience increase, with greater rewards for excellence and more significant penalties for poor performance.

The Department will monitor a wide range of processes and outcomes relevant to managed care, which are shown in Appendix A. One subset of measures (shown in Appendix A, Tables 3 and 4) includes measures that are the priority focus for plan accountability. These measures, which will primarily be calculated by plans, will comprise the set from which plans can draw measures for required quality improvement initiatives such as PIPs. Eventually, the Department will use a limited subset of these measures as part of its quality withhold program as well. In addition, the Department will calculate and monitor a separate, larger set of measures on health care delivery and outcomes in the Medicaid program (Appendix A, Table 6).

Behavioral Health I/DD Tailored Plans will also be responsible for a set of measures to assess the quality of state-funded services, which address the unique needs of individuals receiving state and non-Medicaid federally funded services for mental health, I/DD, traumatic brain injury and substance abuse (see Appendix A, Table 5). For several of these state-funded services measures, Behavioral Health I/DD Tailored Plans will be held financially accountable starting in Contract Year 1, as Local Management Entities/Managed Care Organizations (LME/MCOs) are today.

Plan-level performance on all measures shown in Appendix A, Tables 3 and 4 will be publicly reported, and plan-level performance on measures shown in Appendix A, Tables 5 and 6 may be publicly reported.

The Department's Quality and Health Outcomes Committee will review quality measure performance results, updates to technical specifications and stakeholder feedback (including from managed care plans) at least annually to inform an annual quality measure set monitoring and update process.

These quality measures are meant to provide the Department with a view of the Standard Plans and Behavioral Health I/DD Tailored Plans processes and performance in a format that will be specified by the Department.³ These measures were selected from a variety of sources, including Healthcare Effectiveness Data and Information Set (HEDIS®) measures; National Committee for Quality Assurance (NCQA) health plan accreditation requirements, including a requirement for Long-Term Services and Supports (LTSS) accreditation; and Centers for Medicare & Medicaid Services (CMS) Adult and Child Core measure sets.⁴

The Department will update all quality measures annually to reflect changes in these sets as the foci of the Department's quality improvement efforts evolve. In the measurement of low birth weight and very low birth weight, the Department has modified an existing measure for use in the managed care setting. The sections below discuss the Department's overall approach to quality and administrative

³ The EQRO will report Consumer Assessment of Healthcare Providers and Systems measures at the plan level.

⁴ Standard Plans and Behavioral Health I/DD Tailored Plans will be required to secure NCQA accreditation by Year 3.

reporting, followed by a review of approaches to specific areas of measurement the Department would like to highlight. Those areas include:

- Modified Measures
- Utilization Management Measures
- Select Administrative Measures
- Survey-based Measures
- Public Health Measures

The technical specifications for all measures that will be reported by Standard Plans and Behavioral Health I/DD Tailored Plans (to include state-funded services measures) are shown in Appendix D and E. The appendices also include measures that the Department will calculate. The Department has emphasized measures that can be reported using only administrative data, but will accept a hybrid reporting approach for measures for which hybrid reporting is appropriate as indicated in the measure's specifications.⁵ However, the Department reserves the right to suspend hybrid reporting as necessary, such as in the case of a disaster or state of emergency. The Department encourages Standard Plans and Behavioral Health I/DD Tailored Plans to pursue hybrid reporting to develop consistent data collection approaches that minimize administrative burden for providers.

The Department aims to work with the state's designated Health Information Exchange (HIE), NC HealthConnex, to create a clinical data conduit for NC Medicaid Managed Care. To do this, NC HealthConnex will work with the Department to ensure that all Medicaid Managed Care providers with the capacity to do so, including labs, registries and long-term care facilities, are submitting complete, accurate data to the HIE. NC HealthConnex will use some of this data to produce an initial set of prioritized Electronic Clinical Quality Measures (eQMs)

- Controlling High Blood Pressure⁶
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)⁷
- Preventive Care and Screening: Screening for Depression and Follow-up Plan⁸
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents⁹

The Department, Standard Plans and Behavioral Health I/DD Tailored Plans will access clinical data needed for quality measurement through NC HealthConnex, thereby reducing providers' workload.

⁵ The hybrid reporting method involves the use of both administrative data (such as claims/encounter data) and medical record review.

⁶ Specifications for the eQM – Controlling High Blood Pressure can be found here: <https://help.practicefusion.com/s/article/2020-eQM-Controlling-High-Blood-Pressure-CMS-165v8>

⁷ Specifications for the eQM – Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) can be found here: <https://ecqi.healthit.gov/ecqm/ep/2019/cms122v7>

⁸ Specifications for the eQM – Preventive Care and Screening: Screening for Depression and Follow-Up Plan can be found here: <https://ecqi.healthit.gov/ecqm/ep/2020/cms002v9>

⁹ Specifications for the eQM – Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents can be found here: <https://ecqi.healthit.gov/ecqm/ep/2019/cms155v7> .

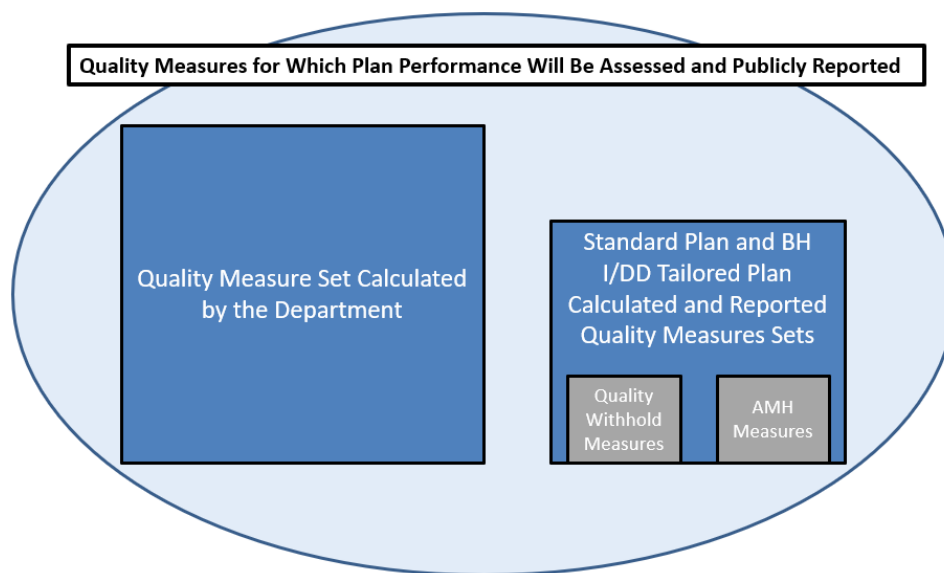
Medicaid Managed Care plans and AMHs can share clinical information on patients enrolled in a variety of care management and population health programs, improving coordination of care for patients and reducing administration burden for providers and plans.

A. Quality and Administrative Measure Reporting

The Standard Plan and Behavioral Health I/DD Tailored Plan measure sets are aligned with North Carolina's Aims, Goals and Objectives.¹⁰ Beginning in the third contract year, the Department will hold Standard Plans and Behavioral Health I/DD Tailored Plans financially accountable for their performance on a set of **quality withhold measures**. The Department will draw from their respective measure sets in the corresponding calendar year, as shown in Figure 2 and outlined further in the appendices. See Figure 3 in Section IV for further information on the timing of financial accountability.

The Department will also establish a list of measures that Standard Plans can use for developing performance payments to AMH practices. In the future Behavioral Health I/DD Tailored Plans can use for these measures for AMH+s and CMAs (described further in Section V(D)). Standard Plans and Behavioral Health I/DD Tailored Plans should draw from their measure sets for any non-AMH PIPs and value-based contracting arrangements.

Figure 2: Quality and Administrative Measure Reporting Framework



The following subsections outline quality measures of particular interest to stakeholders, including measures that are unique to North Carolina, measures that have changed based on public and stakeholder feedback and select measures that Standard Plans and Behavioral Health I/DD Tailored Plans will be required to report (see Appendices A, D and E for more information).

¹⁰ Further described in the North Carolina Quality Strategy, available here: <https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement>

B. Modified Measures

As part of the NC Medicaid Managed Care transformation process, the Department is requiring Standard Plans and Behavioral Health I/DD Tailored Plans engagement in reporting low birth weight. The Department seeks to understand how babies are faring under the transition to managed care and to reward Standard Plans and Behavioral Health I/DD Tailored Plans that decrease rates of low birth weight in their assigned population.

The Department modified an existing measure to account for the Standard Plans and Behavioral Health I/DD Tailored Plans role in addressing low birth weight rates. Since the Department intends to hold Standard Plans and Behavioral Health I/DD Tailored Plans accountable for their efforts to reduce low birth weight babies in their assigned populations, it developed a modified version of the Live Births Weighing Less than 2500 Grams measure (National Quality Forum (NQF # 1382), a widely used metric, which assesses rates of low and very low birth weight at the geographic level, such as a county or state.^{11,12}

The Department expects Standard Plans and Behavioral Health I/DD Tailored Plans to report on the measure elements requested below, including the measure's denominator and number of exclusions, both overall and based on the required stratifications, and to respond to supplemental requests for data the Department may issue. The Department will coordinate with Standard Plans, Behavioral Health I/DD Tailored Plans and the North Carolina Department of Health and Human Service's division of Vital Records (Vital Records).

Low Birth Weight Outcomes Measure

The Department selected this measure because low birth weight is an important cause of morbidity for North Carolina children. Standard Plans and Behavioral Health I/DD Tailored Plans can take steps to reduce low birth weight in their assigned populations. In 2019, North Carolina ranked 43rd among the 50 states for its rate of low birth weight babies (9.2%), reflecting the unacceptable high rate of low birth weight babies born in the state each year.¹³ These high rates, in turn, are associated with higher rates of poor health outcomes and higher health care spending. While the common quality measures of low birth weight are assessed at the state level, the Department modified this measure to assess at the plan level to better monitor and support plan efforts in this area.

10 An alternative measure of low birth weight rate, NQF# 0278 (Prevention Quality Indicator (PQI) #9), measures a similar concept, but uses claims data to identify cases of low birth weight. The Department has elected to use NQF# 1382 because it uses vital statistics data (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3492503/>). In future years, the Department intends to compare the accuracy of claims data against birth certificate data in identifying low birth weight and may transition to a claims-based measure.

12 To modify the Percentage of Low Birth Weight Births measure so that it can be used to measure plan accountability, the Department convened a short-term workgroup comprising physicians, researchers, epidemiologists and state staff. Developing technical specifications for a new measure according to the full process recommended in the CMS Measures Management System (MMS) Blueprint typically requires more than a year and substantial investment of resources. Because the Department sought to modify an existing measure rather than develop an entirely new measure, the Department used a limited adaptation of the MMS process involving a series of structured expert workgroups to address key issues, with a particular focus on ensuring the eventual measure retained face validity and did not put beneficiaries at risk.

¹³ United Health Foundation. America's Health Rankings: North Carolina, 2019. Available at: https://www.americashealthrankings.org/explore/annual/measure/Birth_Weight/state/NC

This modified measure assesses rates of low birth weight (<2500 grams) and very low birth weight (<1500 grams) at the plan level, considering only singleton, live birth deliveries because multiple gestations are more likely to have low birth weight for reasons unrelated to health care delivery. The measure also excludes babies born weighing less than 300 grams. The measure only considers deliveries where the mother has had continuous coverage with the same plan from 16 weeks gestation or earlier, to ensure that Standard Plans, Behavioral Health I/DD Tailored Plans and providers have opportunities to intervene where possible.

While the measure focuses on women who are already pregnant, the Department believes that an effective approach to reducing low birth weight risk involves interventions prior to conception, and encourages Standard Plans and Behavioral Health I/DD Tailored Plans to consider addressing health risks that contribute to low birth weight for members who expect to become pregnant (see Appendix B for further information).

Future Plans for Low Birth Weight Quality Measures

The Department will publicly report plan performance on the modified low birth weight outcome measure for the first year of NC Medicaid Managed Care, with explanatory language describing the pilot nature of the measure and providing appropriate guidance for interpreting results associated with small sample sizes. Based on Standard Plans and Behavioral Health I/DD Tailored Plans respective performance in the first two years of measure reporting, the Department may elect to modify the measure.

C. Measures of Utilization

The Department has added measures of utilization to the quality measure set to assess the degree to which Standard Plans and Behavioral Health I/DD Tailored Plans care management and utilization management efforts are able to reduce avoidable utilization. The Department will calculate results for the following measures and will share results with Standard Plans and Behavioral Health I/DD Tailored Plans:

- Hospital readmissions (measured using NQF# 1768, Plan All-cause Readmissions)

The Plan All-cause Readmissions (PCR) measure in the Medicaid Adult and Health Home Core Sets assesses the percentage of acute inpatient hospital discharges resulting in an unplanned hospital readmission within 30 days. The Department will calculate the observed versus expected ratio for this measure, which is the ratio of the actual (observed) count of readmissions in relation to the risk-adjusted (expected) count of readmissions. The count of expected readmissions is a prediction of the state's performance based on its demographic and clinical case mix in the NC Medicaid Managed Care population. It is typically calculated by classifying the state's case mix and applying risk weights to each eligible hospital stay.

- Total Cost of Care (IBM Watson Cost of Care Model)

Standard Plans and Behavioral Health I/DD Tailored Plans may elect to calculate additional measures of avoidable utilization as part of their internal processes at any time with the provision that these measures should not be used to adjudicate the appropriateness of

specific Emergency Department (ED) visits and hospital admissions, as they are not validated for this purpose nor used in any PIP. The Department may calculate additional measures or different measures of avoidable utilization in future years.

D. Select Administrative Measures

Screening for Unmet Health-related Social Needs

This measure assesses whether Standard Plans and Behavioral Health I/DD Tailored Plans are screening all members to determine if they have needs in the areas of housing, safety from interpersonal violence, transportation and food insecurity. The denominator captures all members in a plan's enrolled population, and the numerator is all members who have been screened within 90 days of enrollment as per contract requirements. The Department has provided the specific questions to be used in this screening.¹⁴

To report on this measure, Standard Plans and Behavioral Health I/DD Tailored Plans need to capture the dates which screenings are completed so that they can calculate the number of days' difference between successful screening completion and member enrollment. While the NC Medicaid Managed Care contracts require plans make at least two attempts to screen within the 90-day period, this measure captures how many screenings the plan has successfully completed. (See Appendix D for additional information required to calculate this measure.)

Standard Plans and Behavioral Health I/DD Tailored Plans should expect this measure to recur as an annual requirement for both newly enrolled and re-enrolling members. Standard Plans and Behavioral Health I/DD Tailored Plans are required to conduct a screening on all newly-enrolled members within 90 days (expedited for Aged/Blind/Disabled (ABD) and high-acuity individuals enrolled in Behavioral Health I/DD Tailored Plans), and the transferring plan is also required to submit the most recent screening.

Screening for Pregnancy Risk

This measure captures whether Standard Plans and Behavioral Health I/DD Tailored Plans contracted pregnancy care providers are administering pregnancy risk screenings in a timely manner. The denominator includes all a plan's enrolled population with a reported pregnancy during the measurement year, excluding those with a documented nonviable pregnancy at the first prenatal visit (since administering a pregnancy risk screening would be inappropriate under those circumstances).

The numerator is all members for whom the plan's contracted providers (including obstetricians, local health departments or other designated providers) administer a pregnancy risk screening form and bill the plan. (See Appendix D for additional information required to calculate this measure.) The Department will report this measure with appropriate guidance in interpreting results reflecting small population sizes.

¹⁴ Screening questions are available at: <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions>.

E. Select Survey-based Measures

Provider Survey

The Department, in partnership with a third party, will distribute an annual survey to providers assessing their satisfaction with each plan. The Department will request Standard Plans and Behavioral Health I/DD Tailored Plans support in developing a sampling frame and conducting outreach for this survey.

CAHPS Measures

The Department will use tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult v5.0 and Children v4.0, Chronic Condition Supplemental, Experience of Care and Health Outcomes (ECHO) and Home and Community-based Services surveys to assess patient experience in receiving care.

The Department will evaluate survey responses related to patients' ability to obtain needed care, to get care quickly, coordination of care, customer service, patient rating of the health plan, rating of their personal doctor and rating of the specialist seen most frequently. CAHPS reporting requirements may change to reflect changes in the way NCQA constructs and analyzes the CAHPS survey, for example by retiring certain survey elements. Reporting requirements may change to capture results for historically marginalized subpopulations.

F. Public Health Measures

The Department envisions Standard Plans and Behavioral Health I/DD Tailored Plans serving as active partners in meeting Healthy NC 2030 goals. To advance this vision, the Department will review a select set of public health population-level outcome measures expected to be affected by activities by Standard Plan and Behavioral Health I/DD Tailored Plan. These measures are meant to assess the association between plan-level efforts around Healthy NC 2030 priorities and health improvements at the population level.

The Department will report on select survey-based public health measures at both the population level and level of the NC Medicaid Managed Care program and review them against related plan performance measures. The Department may reach out to Medicaid Managed Care plans to discuss performance improvement opportunities related to these select public health measures. For Year 1, the Department will report the following rates, based on the Behavioral Risk Factor Surveillance System Survey:

- Percentage of adults who are current smokers
- Percentage of high school students using tobacco
- Percentage of women who smoke during pregnancy
- Exposure to secondhand smoke in the workplace
- Fruit and vegetable consumption among adults
- Percentage of adults getting the recommended amount of physical activity

- Unintentional poisoning mortality rate

IV. Required Reporting Activities for Standard Plans and Behavioral Health I/DD Tailored Plans

Standard Plans and Behavioral Health I/DD Tailored Plans will be required to report on measures in each plan type's respective measure set (listed in Appendix A) as part of their contractual obligations under NC Medicaid Managed Care, including annual and gap reporting described below. These reports will support a wide range of activities including ongoing Department quality monitoring and state submission of quality measure sets to CMS. The Department will combine data and narrative reports submitted by Standard Plans and Behavioral Health I/DD Tailored Plans in addition to internal Department-calculated data to develop and release public-facing reports.

Quality measure reporting will begin with the launch of Medicaid Managed Care. Quality measures are typically specified for measurement based on a **calendar** year, while the Department will contract with Standard Plans and Behavioral Health I/DD Tailored Plans on a **contract** year.

Each contract year, Standard Plans and Behavioral Health I/DD Tailored Plans will submit quality performance data collected during the calendar year that began immediately before the contract year. The first observation period Standard Plans and Behavioral Health I/DD Tailored Plans will report standardized quality measures is Calendar Years 2022 and 2023, respectively. (Figure 3 provides a detailed comparison of quality performance years and contract years.)

Figure 3: Timelines for Quality Measurement and Contracting

Figure 3.1 Standard Plan Timeline

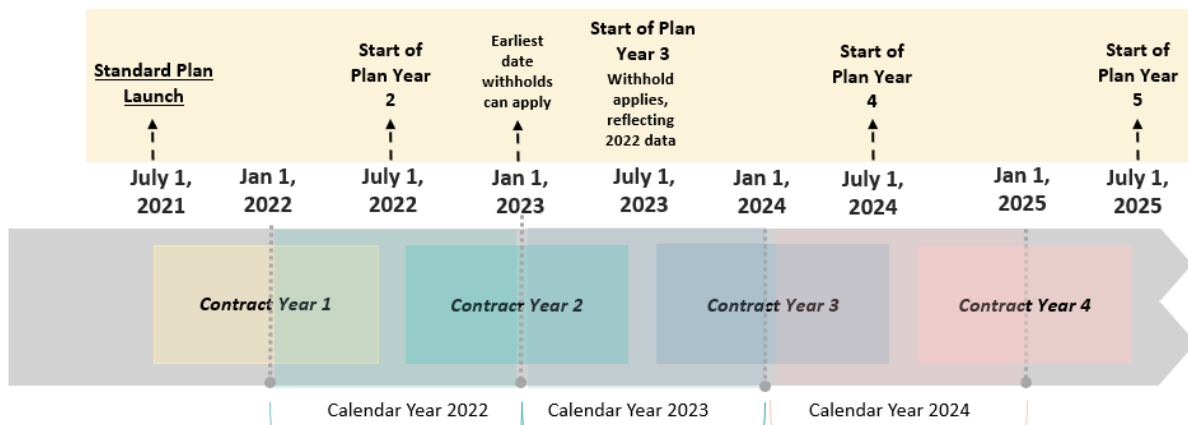


Figure 3.2 Behavioral Health I/DD Tailored Plan Timeline



The remainder of this section discusses timing and types of required reporting.

A. Gap Reporting Requirements for AMH, AMH+s and CMAs

Standard Plans and Behavioral Health I/DD Tailored Plans are required to provide **gap reports** for selected measures to AMHs and AMH+/CMAs, respectively. Because gap reports may contain protected health information, Standard Plans and Behavioral Health I/DD Tailored Plans are expected to identify secure modes of transmission and to notify the Department immediately in the event of a privacy breach.

B. Stratified Reporting Requirements

The Department aims to promote equitable health outcomes for NC Medicaid enrollees. Standard Plans and Behavioral Health I/DD Tailored Plans are expected to report results that are stratified, where applicable, using the stratified reporting details indicated in each measure's technical specification.

HEDIS measures meet rigorous development and evaluation criteria. As such, entities using HEDIS measures may not alter, enhance or otherwise modify HEDIS measures and specifications in ways that are not consistent with the HEDIS Rules for Allowable Adjustment. Entities seeking to modify HEDIS measure specifications should consult the Rules for Allowable Adjustment to determine whether these modifications are permissible.

For measures lacking stratification details, Standard Plans and Behavioral Health I/DD Tailored Plans should use the distinctions outlined in Table 1. Consistent with the Rules for Allowable Adjustments, Standard Plans and Behavioral Health I/DD Tailored Plans should only use Department-defined measure stratifications shown in Table 1 if:

- a measure's specification does not include stratification
- the measure's specification does not explicitly prohibit use of additional stratifications

If a measure's specification does not allow for additional stratifications, the plan should use the stratifications listed in the specification rather than the stratification listed in Table 1. Further, if a measure specification includes stratification but lacks stratification for a particular element (e.g., age, race) included in the Department-defined stratification shown in Table 1, the plan should report according to the Department-defined stratification. The Department will suppress small cell sizes before publicly reporting stratified results and will consider the effects of small sample size in its evaluation of Standard Plans and Behavioral Health I/DD Tailored Plans stratified performance rates.

Table 1. Stratified Reporting Elements

Stratification Element	Strata	Source
Age	For pediatric measures: 0–1, 2–3, 4–6, 7–10, 11–14, 15–18, 19–20, 21 For maternal health: <19, 19–20, 21, 22–24, 25–34, 35+ For adult/full pop. measures: 0–18, 19–20, 21, 22–44, 45–64, 65+	DHHS enrollment data
Race/Ethnicity	Hispanic, Non-Hispanic Black, Non-Hispanic White, American Indian/Alaska Native, Asian/Pacific Islander, Other	DHHS enrollment data (self-reported where possible)
Gender	Male, Female, Third Gender (Other)	DHHS enrollment data (self-reported where possible)
Primary Language	English, Spanish, Other	DHHS enrollment data (self-reported where possible)
LTSS Needs Status	ABD, Non-ABD	Managed care plan screening
Disability Status	Disability, No Disability	DHHS enrollment data
Geography	Rural, Urban	DHHS enrollment data
Service Region	Standard Plans: 1–6 Behavioral Health I/DD Tailored Plans: 1–7	DHHS enrollment data

V. Assessing Performance

The Department will assess Standard Plans, Behavioral Health I/DD Tailored Plans and providers quality performance in several ways. This section details how Standard Plans and Behavioral Health I/DD Tailored Plans will be held accountable, as well as the measures plans will be able to deploy at the provider level to reward providers for high-quality outcomes. It also describes the Department's

public reporting process, which will support statewide engagement (including with Standard Plans and Behavioral Health I/DD Tailored Plans) around population health goals.

A. How the Department will Assess Standard Plans and Behavioral Health I/DD Tailored Plans Performance on Quality Measures

Standard Plans and Behavioral Health I/DD Tailored Plans will be given historical rates, calculated by the Department, for all measures where comparable historical data are available at the state level. The Department will also calculate performance benchmarks, representing improved performance levels, for all measures. These performance benchmarks are meant to support Standard Plans and Behavioral Health I/DD Tailored Plans quality improvement efforts but are not linked to financial accountability. Over time, performance benchmarks are meant to help the Department identify high-performing Standard Plans and Behavioral Health I/DD Tailored Plans.

Beginning in Contract Year 1, the Department will monitor progress toward meeting performance benchmarks each contract year. The Department expects to see annual progress toward meeting measure performance benchmarks and measure performance improvement will serve as the focus of Standard Plans and Behavioral Health I/DD Tailored Plans QAPI programs and PIPs. Standard Plans and Behavioral Health I/DD Tailored Plans will be held financially accountable for performance measured against a different performance benchmark, designated as the withhold target, for a smaller subset of measures beginning in the third contract year for their respective enrolled populations. These withhold targets will reflect a performance level to ensure meaningful improvement for NC Medicaid Managed Care enrollees. Further discussion of these measures and performance benchmarks can be found in Section V(C).

The Department has developed a performance benchmarking approach for use in quality measurement. Performance benchmarks are used to support plan-Department conversations around goal-setting and are not publicly reported or used to determine withhold target allocation.¹⁵

The updated performance benchmarking approach is as follows:

- For the first two years of Medicaid Managed Care implementation, the Department will set a benchmark for each measure (except for measures of contraceptive care) of 105% of NC Medicaid's prior year overall performance for the measure. Standard Plans and Behavioral Health I/DD Tailored Plans will each be compared against their respective program's historical performance (i.e., Medicaid Managed Care plan-level targets will be a 5% relative increase from the previous year's product-line-wide rate).
- For the third plan year and beyond, the Department will monitor performance and may adjust the benchmarking methodology.

For measures of contraceptive care, the Department will not apply an external performance benchmark, reflecting the preference-sensitive nature of contraception care. The Department will, however, monitor measure results to assess where contraceptive access may be problematic.

¹⁵ As per S.L. 2018-49, withhold targets will not be implemented until the third contract year. A methodology to determine the quality score required to receive a withhold target allocation will be released prior to that year.

B. Promoting Equity in Care and Outcomes

The Department expects Standard Plans and Behavioral Health I/DD Tailored Plans to ensure improvements in quality are equitably distributed with no segments of the population ignored. In support of this goal, the Department will require Standard Plans and Behavioral Health I/DD Tailored Plans to participate in activities promoting health equity, and beginning in the third contract year, will hold them financially accountable for ensuring equity in improvements for selected measures.

Standard Plans and Behavioral Health I/DD Tailored Plans are expected to engage with the Department's designated EQRO, which will develop an annual health equity report. The Department will use this report to guide development of subpopulation specific quality improvement strategies. This will start with systematic identification of disparities in the NC Medicaid Managed Care program and progress to rewarding Standard Plans and Behavioral Health I/DD Tailored Plans that generate more equitable improvement in outcomes for their enrolled members. In Year 1, the requirement is limited to stratified reporting.

The Department will identify selected measures with significant disparities, defined as greater than 10% relative gap in performance between a group of interest and a reference group. In their evaluation of plan performance on these measures, the Department will assess whether disparities have narrowed through performance improvement, specifically for the subpopulation experiencing the disparity, in addition to consideration of overall performance improvement for each plan's respective enrolled population as compared to their Standard Plan or Behavioral Health I/DD Tailored Plan peers. Specifically, the Department expects a 10% relative improvement in the performance for the group of interest as compared to the performance of the overall population for at least two years **and** until the gap between a group of interest and the overall population is less than a relative 10%.¹⁶

Each year the EQRO will prepare a health equity report documenting progress toward the goal of reducing disparities and sharing Standard Plans and Behavioral Health I/DD Tailored Plans stratified quality performance. The EQRO will identify disparities most closely associated with disparate health outcomes and will incorporate rewards for reducing or eliminating these disparities into the withhold measure set as soon as feasible.

C. Future Uses of Quality Withhold Targets and Overall Quality Results

Beginning the third contract year, the Department will measure Standard Plans and Behavioral Health I/DD Tailored Plans performance against select **withhold measures**, for which plans will be financially accountable. The withhold measures will be drawn from the set of measures Standard Plans and Behavioral Health I/DD Tailored Plans reported the previous year.

For withhold measures, the Department will calculate **withhold targets**, representing the level Standard Plans and Behavioral Health I/DD Tailored Plans must achieve to receive some or all their quality withhold amount. The Department aims to maintain a small withhold measure set, ensuring each measure carries sufficient weight to influence plan behavior. The Department may also

¹⁶ The Department's disparities definition and incremental targeting approach are still being finalized.

consider weighting measures, by assigning different percentages of the total withheld amount by measure rather than assigning an equal percentage to each measure. The Department has identified the following as potential withhold measures for Standard Plans. Note this list is subject to change prior to implementation:

- Prenatal and Postpartum Care
- Low Birth Weight
- Well-child Visits in the First 30 Months of Life
- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Initial withhold measures for Behavioral Health I/DD Tailored Plans will be shared prior to Behavioral Health I/DD Tailored Plan launch.

The withhold measure set will shift toward outcome measures over time, with an increasing focus on improving performance under a gap-to-goal assessment approach as well as eliminating disparities. In future years, the Department will implement new uses for Standard Plans and Behavioral Health I/DD Tailored Plans quality scores that go beyond calculation of withhold targets. For example, the Department will expect Standard Plans and Behavioral Health I/DD Tailored Plans to further incorporate quality scores into internal ongoing quality improvement and value-based purchasing efforts.

The Department will use quality scores in the managed care plan auto-assignment algorithm, allowing Standard Plans and Behavioral Health I/DD Tailored Plans with higher quality scores to be assigned proportionally more new beneficiaries. If quality performance is unacceptably low over a continued period, the Department may terminate or decline to renew a managed care contract.

D. Practice-level Quality Measurement for Advanced Medical Homes

The Department requires Standard Plans to monitor the performance of AMHs in all tiers to ensure delivery of high-quality care but expects Standard Plans use of practice-level monitoring to be sensitive to limitations such as population size. All practices will be eligible to earn negotiated Performance Incentive Payments based on the set of measures in Table 2, which were selected for their relevance to primary care and care coordination. These payments are optional for Tier 1 and 2 AMHs.

Standard Plans are required to offer opportunities for such payments to Tier 3 AMHs. Standard Plans are not required to use all the AMH measures, but any quality measures they choose must be drawn from this set and they are not permitted to use measures drawn elsewhere. If a plan elects to use the measure of Diabetes Control HbA1c >9.0%, it may use this as a pay-for-reporting measure in its contracting until the Department has determined data quality is acceptable, but also has the option of contracting pay-for-performance. The Department will accept results based on hybrid reporting for all measures where hybrid reporting is appropriate.

More information on how Behavioral Health I/DD Tailored Plans will measure performance for AMH+ and CMA practices is forthcoming.

Table 2: Measures Selected for Use in Plan Assessments of AMH Practice Quality

NQF#	Measure Name	Steward	Frequency ¹⁷
Pediatric Measures			
NA	Child and Adolescent Well-are Visits (WCV)	NCQA	Annually
0038	Childhood Immunization Status (Combo 10) (CIS)	NCQA	Annually
1407	Immunizations for Adolescents (Combo 2) (IMA)	NCQA	Annually
NA	Well-child Visits in the First 30 Months of Life (W30)	NCQA	Annually
Adult Measures			
0032	Cervical Cancer Screening (CCS)	NCQA	Annually
0033	Chlamydia Screening in Women (CHL)	NCQA	Annually
0018	Controlling High Blood Pressure (CBP)	NCQA	Annually
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)	NCQA	Annually
1768	Plan All-cause Readmissions (PCR) [Observed versus expected ratio]	NCQA	Annually
0418/ 0418e	Screening for Depression and Follow-up Plan (DSF)	CMS	Annually
NA	Total Cost of Care	IBM Watson Health Cost of Care Model	Annually

E. Public Reporting of Performance

The Department intends to report Standard Plans and Behavioral Health I/DD Tailored Plans quality performance publicly wherever feasible and appropriate, as this is an important step in promoting high-quality care and increasing stakeholder awareness of Behavioral Health quality performance. The Department will publish several reports to apprise the public of plan performance and promote transparency in the overall quality in the NC Medicaid Managed Care program. These reports will include:

- *Accreditation Progress and Results*—All Standard Plans and Behavioral Health I/DD Tailored Plans will be required to receive plan accreditation through NCQA. The Department will publish plan progress toward receiving accreditation and will report the accreditor’s findings for each plan during its accreditation process.
- *Annual Quality Measures at Plan Level*—The Department will share plan-level rates for the quality measures described in Section III, to facilitate comparison among plans. Beneficiaries and the public should have access to a reliable report on how plans are performing on specific elements. To that end, the Department will produce a report that will share plan-level quality measures described in Section III. Over time, plan performance may be used to inform other state actions (e.g., auto-assignment).

¹⁷ Monthly gap measure reports are also required.

- *Health Equity Report*—The Department will assess disparities in care and outcomes across the demographics described in Section IV(B), and publish a report summarizing areas of care in which disparities have improved, persisted or developed.
- *Provider Survey Results*—The Department, in partnership with a third party, will field a survey to providers assessing their satisfaction with the plan(s) with which they have contracted. The Department will publish overall satisfaction rates and other findings from this survey.
- *CAHPS Survey Results*—The Department, in partnership with a third party, will field the CAHPS surveys to assess the patient care experience, The Department will publish overall ratings of plans and all care received in addition to other findings from this survey. The Department is considering other methods of sharing plan performance data, including plan report cards with aggregate quality data collected from each plan. The Department will share additional details should it introduce these reports.
- *Other Surveys*—The Department may report the results of other surveys and instruments, particularly those related to quality of life or functional status. More information about these instruments will be available to plans before they are implemented.
- *Access Report*—The Department, in partnership with a third party, will issue a report summarizing secret shopping findings and other metrics of access for each plan.

VI. Conclusion and Next Steps

The Department will engage with Standard Plans and Behavioral Health I/DD Tailored Plans as their quality measurement approach develops. The Department's selection of quality measures will likely change annually, reflecting the evolution of quality priorities as the transformation to NC Medicaid Managed Care continues. In addition, the Department's measure selection includes measures from several nationally recognized measure sets which are evaluated annually. Each year the Department will release a new list of measures required for reporting and ask for public feedback. The Department aims to maintain a measure set that reflects state-of-the-art quality measurement for Medicaid Managed Care-enrolled populations and will update measures to capture changes in these sets.

The Department will continue to work with the MCAC to seek ongoing, public feedback on quality measure sets and the measurement approach.

VII. Appendices

Appendix A: Table of Quality and Administrative Measures¹⁸

Table 3. Standard Plan Measure Set

This table lists quality measures that will be priority focus for Standard Plan accountability. These measures, which will primarily be calculated by plans, comprise the set that plans can draw

¹⁸ To view the full measure specifications for all NCQA measures, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

measures for required quality improvement activities. An asterisk (*) indicates the measure is calculated by the Department.¹⁹

NQF #	Measure	Steward
Pediatric Measures		
NA	Child and Adolescent Well-care Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA
1407	Immunization for Adolescents (Combination 2) (IMA)	NCQA
NA	Total Eligibles Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	DHHS
2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
NA	Well-child Visits in the First 30 Months of Life (W30)	NCQA
Adult Measures		
0032	Cervical Cancer Screening (CCS)	NCQA
0033	Chlamydia Screening in Women (Total Rate) (CHL)	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)	NCQA
0018	Controlling High Blood Pressure (CBP)	NCQA
0039	Flu Vaccinations for Adults (FVA, FVO)*	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)* ²⁰	NCQA
0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
0418/ 0418e	Screening for Depression and Follow-up Plan (DSF)	CMS
2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	PQA
2950	Use of Opioids from Multiple Providers in Persons Without Cancer (UMP)	PQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
1768	Plan All-cause Readmissions (PCR) [Observed versus expected ratio]	NCQA
NA	Total Cost of Care*	IBM Watson Health Cost of Care Model
NA	Rate of Screening for Unmet Resource Needs	DHHS
Maternal Measures		
NA	Low Birth Weight ²¹	DHHS
NA	Prenatal and Postpartum Care (PPC)	NCQA
NA	Rate of Screening for Pregnancy Risk	DHHS

¹⁹ Please refer to the Program Guide, available here, for more information on quality measures that must be reported as part of Care Management for High Risk Pregnancy and Care Management for At-Risk Children Programs.

²⁰ Note: this measure may not be stratified by all sub-strata listed Table 1 in Section IV(B).

²¹ The Department will work jointly with plans to calculate and report this measure.

Table 4. Behavioral Health I/DD Tailored Plan Medicaid Measure Set

This lists quality measures that will be the priority focus for Behavioral Health I/DD Tailored Plan accountability; these measures, which will primarily be calculated by plans, will comprise the set that plans can draw measures for required quality improvement activities. An asterisk (*) indicates that the measure is calculated by the Department.

NQF#	Measure Name	Steward
Pediatric Measures		
NA	Child and Adolescent Well-care Visits (WCV)	NCQA
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA
0108	Follow-up for Children Prescribed ADHD Medication (ADD)	NCQA
1407	Immunization for Adolescents (Combination 2) (IMA)	NCQA
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA
NA	Total Eligibles Receiving at Least One Initial or Periodic Screen (Federal Fiscal Year)	DHHS
2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
NA	Well-child Visits in the First 30 Months of Life (W30)	NCQA
Adult Measures		
0105	Antidepressant Medication Management (AMM)	NCQA
0032	Cervical Cancer Screening (CCS)	NCQA
0033	Chlamydia Screening in Women (CHL)	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC) ²²	NCQA
3389	Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	PQA
3175	Continuation of Pharmacotherapy for Opioid Use Disorder	University of Southern California
0018	Controlling High Blood Pressure (CBP)	NCQA
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA
0039	Flu Vaccinations for Adults (FVA, FVO)*	NCQA
0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC) ^{*23}	NCQA
1768	Plan All-cause Readmissions (PCR) [Observed versus expected ratio]	NCQA
NA	Rate of Screening for Unmet Resource Needs	DHHS
0418/ 0418e	Screening for Depression and Follow-up Plan (DSF) ²⁴	CMS

²²Pending additional information regarding the collection of clinical data.

²³ Note: this measure may not be stratified by all sub-strata listed Table 1 in Section IV(B).

²⁴ Pending additional feedback regarding the collection of clinical data. This measure will be accompanied by future guidance to limit screening in patients where it's not appropriate.

NQF#	Measure Name	Steward
NA	Total Cost of Care*	IBM Watson Health Cost of Care Model
2940	Use of Opioids at High Dosage in Persons Without Cancer (UOD)	PQA
2950	Use of Opioids from Multiple Providers in Persons Without Cancer (UMP)	PQA
Maternal Measures		
NA	Low Birthweight ²⁵	DHHS
NA	Prenatal and Postpartum Care (PPC)	NCQA
NA	Rate of Screening for Pregnancy Risk	DHHS

Table 5. Behavioral Health I/DD Tailored Plan State-funded Measure Set

The following measures assess quality in state-funded services and are reported by Behavioral Health I/DD Tailored Plans, unless otherwise specified. An * indicates the measure is calculated by the Department. Measures with associated liquidated damages are indicated with *italics*.

Measure	Steward	Frequency
Alcohol and Drug Abuse Treatment Center (ADATC) Readmissions within 30 Days and 180 Days	DHHS	Quarterly
Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment	DHHS	Quarterly
Community Mental Health Inpatient Readmissions within 30 Days	DHHS	Quarterly
Community Substance Use Disorder Inpatient Readmission within 30 Days	DHHS	Quarterly
Engagement in Services	DHHS	Quarterly
<i>Housing Retention: Maintains at Least Same Level of Individuals in Supportive Housing as Targeted Under Transitions to Community Living Initiative (TCLI)</i>	DHHS	Quarterly as a point in time on the last day of the quarter
<i>Housing Retention: No Fewer than 90% of People in Supportive Housing Slots Remain in Supportive Housing</i>	DHHS	Quarterly as a rolling 12-month lookback
Initiation of Services	DHHS	Quarterly
State Hospital Readmissions within 30 Days and 180 Days	DHHS	Quarterly
TCLI Population Employment	DHHS	Quarterly
<i>Follow-up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility-based Crisis Services for Mental Health Treatment*</i>	DHHS	Quarterly

²⁵ The Department will work jointly with plans to calculate and report this measure.

Measure	Steward	Frequency
<i>Follow-up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for SUD Treatment*</i>	DHHS	Quarterly

Table 6. Department-calculated Measure Set for Both Standard Plans and Behavioral Health I/DD Tailored Plans

The Department will calculate and monitor the following quality measures in the Medicaid program and reserves the right to report these measures at the plan-level. This list is subject to change.

NQF#	Measure Name	Steward
Pediatric Measures		
N/A	Avoidable Pediatric Utilization PDI 14: Asthma Admission Rate PDI 15: Diabetes Short-term Complications Admission Rate PDI 16: Gastroenteritis Admission Rate PDI 18: Urinary Tract Infection Admission Rate	Agency for Healthcare Research and Quality (AHRQ)
0004	Initiation/Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
NA	Percentage of Eligibles Who Received Preventive Dental Services (PDENT) ²⁶	CMS
2803	Tobacco Use and Help with Quitting Among Adolescents	NCQA
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (the total of all ages for each of the three rates)	NCQA
Adult Measures		
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	CMS
0543	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	CMS
0023	Adult BMI Assessment (ABA) ²⁷	City of New York Department of Health and Mental Hygiene
1800	Asthma Medication Ratio (AMR)	NCQA
N/A	Avoidable Adult Utilization PQI 01: Diabetes Short-term Complication Admission Rate PQI 05: COPD or Asthma in Older Adults Admission Rate PQI 08: Heart Failure Admission Rate PQI 15: Asthma in Younger Adults Admission Rate	AHRQ
2372	Breast Cancer Screening (BSC)	NCQA

²⁶ This measure will be delivered under NC Medicaid Direct; therefore, the Department will calculate measure rates and share them with plans.

²⁷ This measure has been retired by NCQA, but the Department shall continue to calculate it monitoring reasons.

NQF#	Measure Name	Steward
0061	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)	NCQA
0575	Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Poor Control (<8.0%)	NCQA
0057	Comprehensive Diabetes Care (CDC): HbA1c Testing	NCQA
0064	Comprehensive Diabetes Care (CDC): LDL-C Control (<100 mg/dL)	NCQA
0063	Comprehensive Diabetes Care (CDC): LDL-C Screening	NCQA
0547	Diabetes and Medication Possession Ratio for Statin Therapy	NCQA
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA
3488	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	NCQA
2605	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	NCQA
3210/3210e	HIV Viral Load Suppression (HVL)	HRSA
2856	Pharmacotherapy Management of COPD Exacerbation (PCE)	NA
0028	Preventive Care and Screening; Tobacco Use: Screening and Cessation Intervention	PCPI Foundation
2597	Substance Use Screening and Intervention Composite	American Society of Addiction Medicine
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
Maternal Measures		
2904	Contraceptive Care: Access to Long-acting Reversible Contraception (LARC)	US Office of Population Affairs
2903	Contraceptive Care: Most and Moderately Effective Methods	US Office of Population Affairs
2902	Contraceptive Care: Postpartum	US Office of Population Affairs
1382	Live Births Weighing Less Than 2500 Grams ²⁸	CDC
NA	Prenatal Depression Screening and Follow-up (PND)	NCQA
Select Public Health Measures		

²⁸ Calculated at the state level.

NQF#	Measure Name	Steward
NA	Diet/Exercise <ul style="list-style-type: none"> ○ Increase fruit and vegetable consumption among adults ○ Increase percentage of adults who get recommended amount of physical activity Opioid Use <ul style="list-style-type: none"> ○ Reduce the unintentional poisoning mortality rate Tobacco Use <ul style="list-style-type: none"> ○ Decrease the percentage of adults who are current smokers ○ Decrease the percentage of high school students using tobacco ○ Decrease the percentage of women who smoke during pregnancy ○ Decrease exposure to secondhand smoke in the workplace 	NA
Patient Satisfaction²⁹		
0006	CAHPS Survey	AHRQ
Provider Satisfaction		
NA	Provider Survey	DHHS

Appendix B: Measure Modifications: Low Birth Weight and Tobacco Cessation

Low Birth Weight Measure

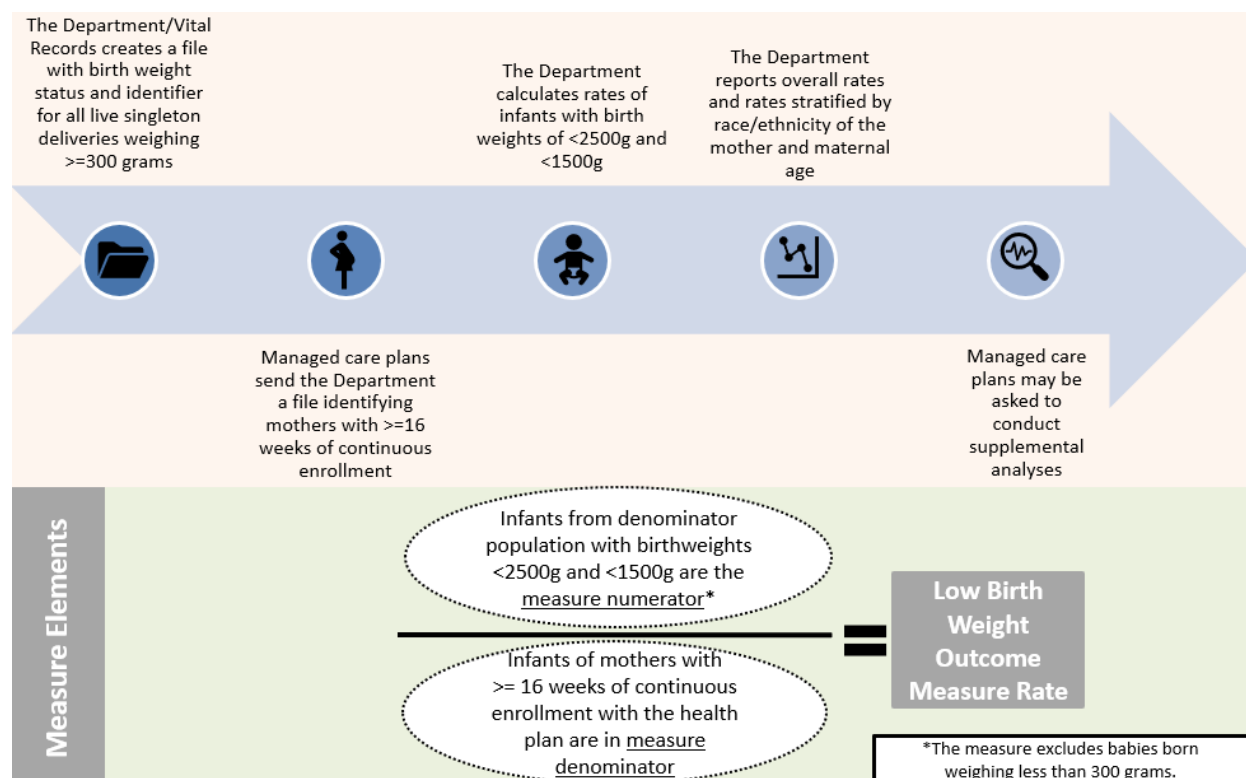
The low birth weight outcome measure will be reported collaboratively between the Department, Standard Plans and Behavioral Health I/DD Tailored Plans. The Department expects collaboration with Standard Plans as follows:

1. The Department will work with Vital Records to obtain birth weight classifications for all live singleton deliveries weighing more than 300 grams during the measurement period and will create a file with the birth weight status and identifier of each infant in the set.
2. Each plan will provide the Department with a file identifying mothers associated with a subset of infants who were continuously covered by the plan from 16 weeks gestation or earlier. This subset of infants will be considered *eligible infants*.
3. The Department will calculate the rate of both low birth weight (<2500 grams) and sub-rate of very low birth weight (<1500 g) among eligible infants in their population. The Department will report overall rates and rates stratified by race/ethnicity of the mother and maternal age.
4. The Department may ask Standard Plans and Behavioral Health I/DD Tailored Plans to conduct supplemental analyses to further refine measure specifications. Examples of such analyses may include comparing low birth weight as reported by V codes to low birth weight as reported by Vital Records data or calculating the measure incorporating additional potential exclusions.

²⁹ The Department is conducting other surveys and will assess survey results in addition to CAHPS to evaluate patient satisfaction, including the DMH/DD/SAS Perceptions of Care Survey.

See Figure 4 for a representation of the process for reporting the low birth weight outcome measure.

Figure 4: Approach to Calculating Low Birth Weight Outcome Measure



To ensure the implementation and use of this measure does not create incentives for Standard Plans and Behavioral Health I/DD Tailored Plans to avoid high-risk patients, the Department will monitor potential plan avoidance of high-risk patients via strategies that may include monitoring plan enrollment and disenrollment patterns for pregnant women, specifically with respect to the 90-day choice period³⁰; monitoring practice referral patterns and plan contracting with practices specializing in low-income or high-risk populations; and reporting at the plan and regional levels to address region-driven variations in populations. In addition, the Department will not publicly report measure performance at the provider or practice level, and Standard Plans and Behavioral Health I/DD Tailored Plans will not be permitted to use the measure in value-based and performance-incentive contracting due to concerns that provider-level samples will be small and unreliable and providers may be discouraged from treating high-risk patients.

Appendix C: Key to Technical Specifications

³⁰ All NC Medicaid Managed Care beneficiaries—whether they select or are assigned to a Standard Plan or Behavioral Health I/DD Tailored Plan—have a 90-day period following the effective coverage date or date of notice of new plan enrollment (referred to as the choice period) to switch Standard Plans and Behavioral Health I/DD Tailored Plans “without cause.” After the completion of the 90-day period, most beneficiaries must remain enrolled in their plan for the remainder of their eligibility period unless they can demonstrate a “with cause” reason for switching. Certain special populations may switch Standard Plans and Behavioral Health I/DD Tailored Plans “without cause” at any time, including members of a federally recognized tribe and beneficiaries receiving LTSS in institutional or community-based settings. All beneficiaries will have the option to switch plans annually at the time of eligibility redetermination.

Measure Name

Descriptive Information

Measure Type

Indicates whether the measure is a process, outcome, or a cost/resource use measure.

NQF Number and Measure Steward

National Quality Forum number and measure steward.

Brief Description of Measure

Short description of the measure focus, target population and timeframe.

Numerator Statement

A brief, narrative description of the measure focus or what will be measured within the target population. If an outcome measure, state the outcome being measured.

Denominator Statement

A brief, narrative description of the target population being measured. If an outcome measure, states the target population for the outcome.

Denominator Exclusions

A brief narrative description of exclusions from the target population.

Appendix D: Specifications for Standard Plan and Behavioral Health I/DD Tailored Plan-Reported Measures**Pediatric Measures****Child and Adolescent Well-Care Visits**

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# NA, Measure Steward: NCQA

Brief Description of Measure

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit during the measurement year.

Numerator Statement

One or more well-care visits (Well-care Value Set) during the measurement year.

Denominator Statement

The eligible population.

Denominator Exclusions

None.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Childhood Immunization Status (Combo 10)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0038, Measure Steward: NCQA

Brief Description of Measure

Percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three Hemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine.

Numerator Statement

Children who received the recommended vaccines by their second birthday.

Denominator Statement

Children who turn two years of age during the measurement year.

Denominator Exclusions

Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates. The denominator for all rates must be the same.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Follow-up for Children Prescribed ADHD Medication (Behavioral Health I/DD Tailored Plan only)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0108, Measure Steward: NCQA

Brief Description of Measure

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

Numerator Statement

Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

Denominator Statement

Children 6–12 years of age newly prescribed ADHD medication.

Denominator Exclusions

Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date.

Children with a diagnosis of narcolepsy. Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Immunizations for Adolescents

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1407, Measure Steward: NCQA

Brief Description of Measure

Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine; and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Numerator Statement

Adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.

Denominator Statement

Adolescents who turn 13 years of age during the measurement year.

Denominator Exclusions

This measure excludes patients who have a contraindication for the vaccine and patients who use hospice services during the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (Behavioral Health I/DD Tailored Plan **only**)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2800, Measure Steward: NCQA

Brief Description of Measure

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Numerator Statement

Children and adolescents 1–17 years of age on antipsychotics who received blood glucose and cholesterol testing during the measurement year.

Denominator Statement

Children and adolescents 1–17 years of age who had ongoing use of antipsychotic medications (at least two prescriptions).

Denominator Exclusions

Patients in hospice.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Total Eligibles Receiving at Least One Initial or Periodic Screen (Federal Fiscal Year)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# NA, Measure Steward: CMS

Brief Description of Measure

Assesses the effectiveness of the state Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program in terms of the number of individuals under the age of 21 (by age group and basis of Medicaid eligibility) who are provided child health screening services.

Numerator Statement

Total number of initial or periodic screens furnished to eligible individuals.

Denominator Statement

Total unduplicated number of individuals under the age of 21 enrolled in Medicaid or a Children's Health Insurance Program (CHIP) Medicaid expansion program determined to be eligible for EPSDT services, distributed by age and by basis of eligibility as of September 30.

Denominator Exclusions

Undocumented aliens who are eligible only for emergency Medicaid services.

Children in separate state CHIP programs.

Other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services).

For more detailed instructions, please see the 2021 CMS-416 Instructions.

Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2801, Measure Steward: NCQA

Brief Description of Measure

Percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication, but no U.S. Food and Drug Administration (FDA) primary indication for antipsychotics and had documentation of psychosocial care as first-line treatment.

Numerator Statement

Children and adolescents 1–17 years of age who had psychosocial care as first-line treatment prior to (or immediately following) a new prescription of an antipsychotic without FDA primary indication for antipsychotic use.

Denominator Statement

Children and adolescents 1–17 years of age as of December 31 of the measurement year who had a new prescription of an antipsychotic medication for which they do not have FDA primary indication for antipsychotics.

Denominator Exclusions

Exclude children and adolescents with a diagnosis of a condition for which antipsychotic medications have FDA primary indication and are thus clinically appropriate: schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder.

Patients in hospice.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Well-Child Visits in the First 30 Months of Life

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# NA, Measure Steward: NCQA

Brief Description of Measure

The percentage of members who had the following number of well-child visits during the last 15 months:

- Children who turned 15 months old during the measurement year with six or more well-child visits.
- Children who turned 30 months old during the measurement year with two or more well-child visits.

Numerator Statement

Six or more well-care visits (Well-care Value Set) on different dates of service on or before the 15-month birthday.

Denominator Statement

The eligible population.

Denominator Exclusions

None.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Adult Measures

Antidepressant Medication Management (Behavioral Health I/DD Tailored Plan only)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0105, Measure Steward: NCQA

Brief Description of Measure

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and remained on an antidepressant medication treatment. Two rates are reported.

- Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (six months).

Numerator Statement

Adults 18 years of age and older who were newly treated with antidepressant medication, had a diagnosis of major depression and remained on an antidepressant medication treatment.

Denominator Statement

Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.

Denominator Exclusions

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who did not have a diagnosis of major depression in an inpatient, outpatient, ED, telehealth, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSP, through the IPSP and the 60 days after the IPSP.

Exclude patients who filled a prescription for an antidepressant 105 days prior to the IPSP.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Cervical Cancer Screening

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0032, Measure Steward: NCQA

Brief Description of Measure

Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every three years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Numerator Statement

The number of women who were screened for cervical cancer.

Denominator Statement

Women 24–64 years of age as of the end of the measurement year.

Denominator Exclusions

Members in palliative care. Women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Chlamydia Screening in Women

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0033, Measure Steward: NCQA

Brief Description of Measure

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Numerator Statement

Females who were tested for chlamydia during the measurement year.

Denominator Statement

Females 16–24 years who had a claim or encounter indicating sexual activity.

Denominator Exclusions

Females who received a pregnancy test to determine contraindications for medication (isotretinoin) or X-ray.

Patients in hospice.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 0059, Measure Steward: NCQA

Brief Description of Measure

The percentage of patients 18–75 years of age with diabetes (type 1 and 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

Numerator Statement

Patients whose most recent HbA1c level is greater than 9.0% or missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out-of-range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.

Denominator Statement

Patients 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or 2) during the measurement year or the year prior to the measurement year.

Denominator Exclusions

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Concurrent Use of Prescription Opioids and Benzodiazepines

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 3389, Measure Steward: PQA

Brief Description of Measure

The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year.

A lower rate indicates better performance.

Numerator Statement

The number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year.

Denominator Statement

The denominator includes individuals 18 years and older with two or more prescription claims for opioid medications on different dates of service and with 15 or more cumulative days' supply during the measurement year.

Denominator Exclusions

Individuals in hospice or with a cancer or sickle cell disease diagnosis at any point during the measurement year are excluded from the denominator.

Continuation of Pharmacotherapy for Opioid Use Disorder

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 3175, Measure Steward: USC

Brief Description of Measure

Percentage of adults 18–64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.

Numerator Statement

Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.

Denominator Statement

Individuals 18–64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication.

Denominator Exclusions

None.

Controlling High Blood Pressure

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 0018, Measure Steward: NCQA

Brief Description of Measure

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Numerator Statement

The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Denominator Statement

Patients 18–85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.

Denominator Exclusions

- Exclude all patients with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note

indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

- Exclude all patients with a diagnosis of pregnancy during the measurement year.
- Exclude all patients who had an admission to a non-acute inpatient setting during the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (Behavioral Health I/DD Tailored Plan only)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1932, Measure Steward: NCQA

Brief Description of Measure

The percentage of patients 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Numerator Statement

Among patients 18–64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Denominator Statement

Patients ages 18–64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

Denominator Exclusions

- Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Exclude patients with diabetes during the measurement year or the year prior to the measurement year.
- Exclude patients who had no antipsychotic medications dispensed during the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Flu Vaccinations for Adults

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0039, Measure Steward: NCQA

Brief Description of Measure

The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid and commercial populations. It is reported as two separate rates stratified by age: 18–64 and 65 years of age and older.

Numerator Statement

This measure is reported as two rates:

- Flu Vaccination for Adults Age 18–64. Respondents to the Medicaid or commercial CAHPS survey who report having received an influenza vaccination since July of the previous year.
- Flu Vaccination for Adults Age 65+. Respondents to the Medicare CAHPS survey who report having received an influenza vaccination since July of the previous year.

Denominator Statement

- Flu Vaccinations for Adults Ages 18–64. Medicaid and Commercial CAHPS respondents age 18–64.
- Flu Vaccination for Adults Age 65 and Older. Medicare CAHPS respondents age 65 and older.

Denominator Exclusions

None.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Follow-up After Hospitalization for Mental Illness

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0576, Measure Steward: NCQA

Brief Description of Measure

The percentage of discharges for patients six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge.
- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

Numerator Statement

- 30-Day Follow-up. A follow-up visit with a mental health practitioner within 30 days after discharge.
- Seven-Day Follow-up. A follow-up visit with a mental health practitioner within seven days after discharge.

Denominator Statement

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients six years and older.

Denominator Exclusions

- Exclude from the denominator for both rates patients who receive hospice services during the measurement year.
- Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.
- Exclude discharges followed by readmission or direct transfer to a non-acute facility within the 30-day follow-up period regardless of principal diagnosis.
- Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health.

These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Medical Assistance with Smoking and Tobacco Use Cessation

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0027, Measure Steward: NCQA

Brief Description of Measure

The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

- **Advising Smokers and Tobacco Users to Quit.** A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
- **Discussing Cessation Medications.** A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- **Discussing Cessation Strategies.** A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Numerator Statement

Advising Smokers and Tobacco Users to Quit

Patients who indicated that they received advice to quit smoking or using tobacco from their doctor or health provider.

Discussing Cessation Medications

Patients who indicated that their doctor or health provider recommended or discussed smoking or tobacco cessation medications.

Discussing Cessation Strategies

Patients who indicated their doctor or health provider discussed or provided smoking or tobacco cessation methods and strategies other than medication.

Denominator Statement

Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the past six months for Medicaid and Medicare.

Denominator Exclusions

None.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Plan All-Cause Readmissions

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1768, Measure Steward: NCQA

Brief Description of Measure

For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays* (denominator)
- Count of 30-day Readmissions (numerator)
- Average Adjusted Probability of Readmission

*An acute inpatient stay with a discharge during the first 11 months of the measurement year (i.e., on or between January 1 and December 1).

Numerator Statement

At least one acute, unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay that is on or between the second day of the measurement year and the end of the measurement year.

Denominator Statement

Patients age 18 and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between January 1 and December 1 of the measurement year.

Denominator Exclusions

Exclusions are included in the definition of the denominator. Exclusions include discharges for death, pregnancy, perinatal condition or a discharge that is followed by a planned admission within 30 days.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Rate of Screening for Unmet Resource Needs

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The percentage of enrollees who received a screening for unmet health related-social needs.

Numerator Statement

All NC Medicaid Managed Care enrollees for whom the plan completed a social determinants of health screening within 90 days of enrollment. Completed screenings are those screenings for which all questions have been addressed. Staff administering the screenings will have an option to indicate a question was asked but the enrollee chose not to answer.

Denominator Statement

All Medicaid Managed Care enrollees.

Denominator Exclusions

None.

Screening for Depression and Follow-up Plan

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0418/0418e, Measure Steward: CMS

Brief Description of Measure

Percentage of patients age 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter.

Numerator Statement

Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter.

Denominator Statement

All patients age 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.

Denominator Exclusions

Not Eligible

A patient is not eligible if one or more of the following conditions are documented during the encounter during the measurement period:

- Patient has an active diagnosis of depression prior to any encounter during the measurement period.
- Patient has a diagnosed bipolar disorder prior to any encounter during the measurement period.

Denominator Exceptions

Patients with a Documented Reason for not Screening for Depression:

- Patient refuses to participate.
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example, certain court appointed cases or cases of delirium.
- Use of opioids at high dosage in persons without cancer

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2940, Measure Steward: PQA

Brief Description of Measure

The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.

Numerator Statement

Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer.

Denominator Statement

Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days' supply is greater than or equal to 15.

Denominator Exclusions

Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016; or a hospice indicator (Medicare Part D) from the enrollment database.

Use of Opioids from Multiple Providers in Persons Without Cancer

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2950, Measure Steward: PQA

Brief Description of Measure

The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four or more prescribers AND four or more pharmacies.

Numerator Statement

Any member in the denominator who received opioid prescription claims from four or more prescribers AND four or more pharmacies.

Denominator Statement

Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days' supply is greater than or equal to 15.

Denominator Exclusions

Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016; or a hospice indicator from the enrollment database.

Maternal Measures

Prenatal and Postpartum Care

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# NA, Measure Steward: N/A

Brief Description of Measure

The percentage of deliveries of live births between October 8 of the year prior to the measurement year and October 6 of the measure year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- Rate 1 - Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
- Rate 2 - Postpartum Care. The percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

Numerator Statement

This measure assesses whether pregnant women had timely prenatal and postpartum care visits. It has two rates, one assessing the timeliness of prenatal visits and one assessing the timeliness of postpartum visits.

Denominator Statement

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year.

Denominator Exclusions

Non-live births.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Rate of Screening for Pregnancy Risk

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The rate of pregnant enrollees who received a pregnancy risk screening.

Numerator Statement

Number of pregnancy risk screening payments made by plan.

Denominator Statement

Women with a claim for prenatal services.

Denominator Exclusions

Exclude if any of the following documented during first prenatal visit:

- Spontaneous abortion (ICD-10 codes O03.0-O03.9)
- Ectopic pregnancies (O00.0, O00.1, O00.2, O00.8, O00.9)
- Molar pregnancy (O01.0, O01.1, O01.9)
- Other abnormal products of conception (O02.0, O02.1, O02.8, O02.9)
- Complications following induced termination of pregnancy (O04.5–O04.8)
- Complications following ectopic and molar pregnancy (O08.0–O08.9)

Appendix E: Specifications for Behavioral Health I/DD Tailored Plan State-funded Services Measures

ADATC Readmissions within 30 Days and 180 Days

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

This measure provides the number and percent of persons discharged during the measurement period readmitted to a State Alcohol and Drug Abuse Treatment Center (ADATC) within 30 days of discharge.

Numerator Statement

For individuals in the denominator, the number of discharges that were readmitted to an ADATC within 30 calendar days and within 180 days of the discharge. The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

The number of allowable discharges, as defined above, from a state ADATC during the measurement quarter, as recorded in HEARTS, that fall within the responsibility of an LME/MCO to coordinate services.

Denominator Inclusions/Exclusions

Discharges include only those coded as “direct” discharges or “program completion” to sources that fall within the responsibility of an LME/MCO to coordinate services (e.g., to other outpatient and residential non-state facility, self/no referral, unknown, community agency, private physician, other health care, family friends, nonresidential treatment/ habilitation program, other).

Discharges for other reasons (e.g., transfers to other facilities, deaths, discharges to medical visits, etc.); to other referral sources (e.g., court, correctional facilities, nursing homes, state facilities, VA); and out-of-state are not included in the numerator and denominator.

Treat transfers as a continuous inpatient episode. In these cases, count only the discharge from the last facility. For individuals with multiple admissions to an ADATC during the measurement quarter, count all discharges.

Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The measure provides the average length of stay for persons with a principal mental health diagnosis who were discharged during the measurement period from a community psychiatric inpatient facility for acute mental health care.

Numerator Statement

Total number of inpatient days associated with discharges that occurred during the measurement period. This is the sum of the lengths of stay for all discharges during the measurement period, as defined above.

Denominator Statement

Total number of allowable discharges during the measurement period, as defined above.

Denominator Inclusions/Exclusions

The number of days is calculated as the date of discharge minus the date of admission unless the two dates are the same. In that case, the number of days will be one (cannot have “0” days).

Do not include the last day of the stay (unless the last day of the stay is also the admit day).

Calculate length of stay only for persons discharged during the measurement period. Total days include all days associated with the inpatient stay including days before the first day of the measurement period for discharge dates occurring during the measurement period.

Total days do not include days during the measurement period that are associated with discharge dates after the last day of the measurement period. Therefore, do not include days for persons still in the hospital on the last day of the measurement period.

For transfers between inpatient units or facilities to the same service or level of care, be sure to count all days for both units and facilities.

Exclude days associated with intermediate care or partial hospitalization

Community Mental Health Inpatient Readmissions within 30 Days

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

This measure provides the number and percent of consumers readmitted to inpatient mental health facilities within 30 calendar days of the discharge.

Numerator Statement

Total number of discharges in the denominator readmitted within 30 days (inclusive) after the discharge. The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

Total number of discharges during the measurement period.

Denominator Exclusions

None.

Community Substance Use Disorder Inpatient Readmissions within 30 Days

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

This measure provides the number and percent of consumers readmitted to substance abuse treatment facilities within 30 calendar days of the discharge.

Numerator Statement

Total number of discharges in the denominator readmitted within 30 days of the discharge (inclusive). The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

Total number of discharges within the measurement period.

Denominator Exclusions

None.

Initiation of Mental Health Services

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The percentage of children and adults with a new episode of mental health treatment who received initiation of mental health treatment. This is the percentage of members who initiate treatment through an inpatient mental health admission, outpatient visits, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Numerator Statement

Initiation of the mental health treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant
- If the Index Episode was an outpatient, intensive outpatient, partial hospitalization or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization with an mental health emergency diagnosis within 14 days of the index episode start date (inclusive)
- If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive)

Denominator Statement

The eligible population(s) as defined above.

Denominator Exclusions

Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as beginning initiation of treatment.

Engagement in Mental Health Services

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The percentage of children and adults with a new episode of mental health treatment who received Engagement of Mental Health Treatment. This is the percentage of members who initiated treatment and who had two or more additional services with a mental health diagnosis within 34 days of the initiation visit.

Numerator Statement

Initiation of mental health treatment, as defined above, and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any mental health diagnosis within 34 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers to be counted.

For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 34-day engagement period.

If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 34 days of the initiation encounter (inclusive).

Denominator Statement

The eligible population(s) as defined in the description.

Denominator Exclusions

Do not count engagement encounters that include detoxification codes (including inpatient detoxification).

Initiation of Substance Use Disorder Services

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received Initiation of AOD Treatment. This is the percentage of members who initiated treatment through an inpatient AOD admission, outpatient visits, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Numerator Statement

Initiation of the AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant
- If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization with an AOD diagnosis within 14 days of the IESD (inclusive)
- If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive)

Denominator Statement

The eligible population(s) as defined above.

Denominator Exclusions

Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as beginning initiation of treatment.

Engagement in Substance Use Disorder Services

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received Engagement of AOD Treatment. This is the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 34 days of the initiation visit.

Numerator Statement

Initiation of alcohol and other drug treatment, as defined below, and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 34 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers to be counted.

For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 34-day engagement period.

If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 34 days of the initiation encounter (inclusive).

Denominator Statement

The eligible population(s) as defined in the description.

Denominator Exclusions

Do not count engagement encounters that include detoxification codes (including inpatient detoxification).

Housing Retention: Maintains at Least Same Level of Individuals in Supportive Housing as Targeted Under Transitions to Community Living Initiative (TCLI)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The percentage of people in housing on the last day of the quarter.

Numerator Statement

Number of people in housing on the last day of the quarter as a percentage of the LME/MCO housing target.

Denominator Statement

LME/MCO assigned target by DHHS.

Denominator Exclusions

None.

Housing Retention: No Fewer than 90% of People in Supportive Housing Slots Remain in Supportive Housing

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

Percent of people who remain in supportive housing.

Numerator Statement

Number of people in housing slot on the last day of the 12-month period.

Denominator Statement

Number of people in housing at any time during the 12-month period.

Denominator Exclusions

Exclude persons who have died (of natural causes) or people who moved to supportive housing in another LME/MCO catchment area, people who left supportive housing but remained living independently in the community (i.e., not in congregate or facility setting).

State Hospital Readmissions within 30 days and 180 Days*Descriptive Information***Measure Type**

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

This measure provides the number and percent of persons discharged during the measurement period readmitted to a state psychiatric hospital within 30 days and 180 days of discharge.

Numerator Statement

The number of discharges in the denominator readmitted to any state psychiatric hospital within 30 days and 180 days (inclusive) of the discharge date.

The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

The number of discharges, as defined above, from a state psychiatric hospital during the measurement quarter, as recorded in HEARTS, that fall within the responsibility of an LME/MCO to coordinate services.

Denominator Inclusion/Exclusions

Discharges include only those coded as “direct” discharges to sources that fall within the responsibility of an LME/MCO to coordinate services (e.g., to other outpatient and residential non-state facility, self/no referral, unknown, community agency, private physician, other health care, family friends, nonresidential treatment/ habilitation program, other).

Discharges for other reasons (e.g., transfers to other facilities, deaths, discharges to medical visits, etc.); to other referral sources (e.g., court, correctional facilities, nursing homes, state facilities, VA); and out-of-state are not included in the numerator and denominator.

Treat transfers as a continuous inpatient episode. In these cases, count only the discharge from the last facility. For individuals with multiple admissions to a state psychiatric hospital during the measurement quarter, count all discharges.

TCLI Population Employment

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

Percentage of TCLI population in integrated competitive employment (full time or part time) at any point during the year.

Numerator Statement

Number with employment at any point during the year.

Denominator Statement

All TCLI members.

Denominator Exclusions

None.

Department-reported Measures

Follow-up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility-based Crisis Services For Mental Health Treatment

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The percentage of discharges for individuals ages 3–64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, or facility-based crisis service who received a follow-up visit with a behavioral health practitioner within one to seven days of discharge.

Numerator Statement

For discharges included in the denominator, a follow-up visit with a behavioral health practitioner within one to seven days after discharge. Do not include visits that occur on the date of discharge.

Definition of date of discharge:

- Community hospital – the later of the statement coverage period through date or the last line service date + 1 day for bill types 111, 114 or 117 on the 837i.
- State psychiatric hospital – the date of discharge on the HEARTS extract.
- Facility-based crisis (S9484 and S9484HA) – the last date of service billed/paid.
- Facility-based crisis (YP485) – the last date of service billed/paid + 1 day.

Denominator Statement

Discharged alive from a community-based hospital, state psychiatric hospital, or a facility-based crisis service with a discharge date occurring within the measurement period, with a principal mental health diagnosis.

Community-based Hospital includes:

- YP820 (inpatient hospital)
- YP821 (three-way contract – inpatient unit bed day)
- YP822 (three-way contract – enhanced inpatient unit bed day)

Facility-based Crisis includes:

- S9484 (facility-based crisis service)
- S9484CR (facility-based crisis service) – flexibility
- S9484HA (facility-based crisis service – child)
- S9484HA CR (facility-based crisis service – child) – flexibility
- YP485 (facility-based crisis program – Non-Medicaid)
- YP485CR (facility-based crisis program – Non-Medicaid) – flexibility

State Psychiatric Hospital

Include discharges coded as (all three fields must contain one of the listed values).

Discharge Reason =

- Direct Discharge to Inpatient Commitment
- Direct to Outpatient Commitment
- Direct to Substance Abuse Commitment
- Direct by Court Order
- Direct with Approval
- Against Medical Advice Discharge (AMA)

AND Discharge Referral to =

- Acute Care Hospital (inpatient)
- Other
- Other Outpatient and Residential Non-state Facility
- Outpatient Services
- Residential Care
- Self/No Referral
- Unknown

AND Discharge Living Arrangement = All Arrangements Except (Not Equal To)

- Correctional Facility (prison jail training school)
- Psychiatric Hospital
- Developmental Disability Center

Denominator Inclusions/Exclusions

Exclude state psychiatric hospital discharges coded as:

- Discharge Aftercare LME = (blank) and Discharge Referral = “unknown”

- Responsible County or County Discharged To = “out of state”
- Record does not have a valid CNDSID, or the record has a duplicate CNDSID and discharge date

The denominator is based on discharges, not on individuals. If individuals have more than one discharge during the measurement period, include all discharges, except (re)admission or direct transfer within seven days.

If the discharge is followed by (re)admission* or direct transfer within seven days of discharge to a community-based hospital, state psychiatric hospital, ADATC or detox/facility-based crisis service for a principal mental health or principal substance use disorder diagnosis in Appendix C, treat the (re)admission or direct transfer as an extension of the original stay and count only the last discharge.

Use the principal diagnosis of the last discharge to determine which performance measure specifications to use to receive credit for the discharge and follow-up.

- If the principal diagnosis is mental health, continue to use the specifications for this measure.
- If the principal diagnosis is SUD, use the specifications for the Follow-up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility-based Crisis Services for SUD Treatment performance measure.

* to determine the date of (re)admission, use the earlier of the admission date or first line service date on the institutional claim or the first date of service on the professional claim.

Exclude the last discharge if it occurs after the end of the measurement period. In that case, the last discharge would be counted in the measurement period in which it occurs.

Exclude from the denominator any discharge followed by admission or direct transfer within the seven-day follow-up period to:

- psychiatric residential treatment facility (YA230)
- residential treatment level III/IV (H0019, H0019CR)
- residential treatment level II program (H2020, H2020CR)

Follow-up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based-crisis Services for SUD Treatment

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The percentage of discharges for individuals ages 3–64 who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service and received a follow-up visit with a behavioral health practitioner within one to seven days of discharge.

Numerator Statement

For discharges included in the denominator, a follow-up visit with a behavioral health practitioner within one to seven days after discharge. Do not include visits that occur on the date of discharge.

Date of discharge is defined as follows:

- Community hospital – the later of the statement coverage period through date or the last line service date + 1 day for bill types 111, 114 or 117 on the 837i.
- State psychiatric hospital and ADATC – the date of discharge on the HEARTS extract.
- Facility-based crisis (S9484 and S9484HA) – the last date of service billed/paid.
- Detox (H0010 and H2036) and facility-based crisis (YP485) – the last date of service billed/paid + 1 day.

Denominator Statement

Discharged alive from a community-based hospital, state psychiatric hospital, ADATC, or a detox/facility-based crisis service with a discharge date occurring during the measurement period and a principal substance use disorder diagnosis.

Community-based hospital includes:

- YP820 (inpatient hospital)
- YP821 (3-way contract – inpatient unit bed day)
- YP822 (3-way contract – enhanced inpatient unit bed day)

Detox/Facility-based crisis includes:

- H0010 (non-hospital medical detox)
- H0010CR (non-hospital medical detox) – flexibility
- H2036 (medically supervised detox crisis stabilization)
- H2036CR (medically supervised detox crisis stabilization) – flexibility
- S9484 (facility-based crisis service)
- S9484CR (facility-based crisis service) – flexibility
- S9484HA (facility-based crisis service – child)
- S9484HA CR (facility-based crisis service – child) – flexibility

- YP485 (facility-based crisis program – non-Medicaid)
- YP485CR (facility-based crisis program – non-Medicaid) – flexibility

State psychiatric hospital and ADATC:

Include discharges coded as (all three fields must contain one of the listed values)

Discharge reason =

- Direct discharge to inpatient commitment
- Direct to Outpatient Commitment
- Direct to substance abuse commitment
- Direct by court order
- Direct with approval
- Against Medical Advice Discharge (AMA)
- Behavior Problem Discharge [ADATC]
- Therapeutic Discharge [ADATC]
- Personal reasons (situational issue arises, and patient is discharged with treatment team approval, i.e., death in family, family emergency) [ADATC]

AND Discharge referral to =

- Acute care hospital (inpatient)
- Other
- Other outpatient and residential non-state facility
- Outpatient services
- Residential care
- Self/no referral
- Unknown

AND Discharge living arrangement = all arrangements except (Not Equal To)

- Correctional facility (prison jail training school)
- Psychiatric hospital
- Developmental disability center

Denominator Inclusions/Exclusions

Exclude state psychiatric hospital and ADATC discharges coded as:

- Discharge aftercare LME = (blank) and discharge referral = “unknown”

- Responsible county or county discharged to = “out of state”
- Record does not have a valid CNDSID, or the record has a duplicate CNDSID and discharge date

Exclude ADATC discharges coded as the client did not provide consent to release information to an LME/MCO.

The denominator is based on discharges, not individuals. If individuals have more than one discharge during the measurement period, include all discharges, except (re)admission or direct transfer within seven days.

If the discharge is followed by (re)admission* or direct transfer within seven days of discharge to a community-based hospital, state psychiatric hospital, ADATC, or detox/facility-based crisis service for a principal mental health or principal substance use disorder diagnosis in Appendix C, treat the (re)admission or direct transfer as an extension of the original stay and count only the last discharge.

Use the principal diagnosis of the last discharge to determine which performance measure specifications to use and to receive credit for the discharge and follow-up.

- If the principal diagnosis is SUD, continue to use the specifications for this measure.
- If the principal diagnosis is MH, use the Follow-up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility-based Crisis Services for Mental Health Treatment measure.

* to determine the date of (re)admission, use the earlier admission date or first line service date on the institutional claim or the first date of service on the professional claim.

Exclude the last discharge if it occurs after the end of the measurement period. In that case, the last discharge would be counted in the measurement period in which it occurs.

Exclude from the denominator any discharge followed by admission or direct transfer within the seven-day follow-up period to:

- Psychiatric residential treatment facility (YA230)
- Residential treatment level III/IV (H0019, H0019CR)
- Residential treatment level II (program) (H2020, H2020CR)

Appendix F: Specifications for Department-Calculated Measures

Pediatric Measures

Avoidable Pediatric Utilization

Descriptive Information

Measure Type

Rate/Proportion

NQF Number and Measure Steward

NQF# N/A, Measure Steward: AHRQ

Brief Description of Measure

The Department will calculate the following measures of avoidable pediatric hospitalization:

- PDI 16 Gastroenteritis Admission Rate
- PDI 18 Urinary Tract Infection Admission Rate
- PDI 14 Asthma Admission Rate
- PDI 15 Diabetes Short-term Complications Admission Rate

Numerator Statement

Discharges for patients ages 6–17 years that meet the inclusion and exclusion rules for any of the following PDIs:

- PDI 14 Asthma Admission Rate
- PDI 15 Diabetes Short-term Complications Admission Rate
- PDI 16 Gastroenteritis Admission Rate
- PDI 18 Urinary Tract Infection Admission Rate

Denominator Statement

Population ages 6–17 years in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Denominator Exclusions

None.

More information and full specifications are available at:

https://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec_ICD10_v2020.aspx

Initiation/Engagement of Alcohol and Other Drug Dependence Treatment

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0004, Measure Steward: NCQA

Brief Description of Measure

This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported:

- Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

Numerator Statement

- Initiation of AOD Treatment. Initiation of treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.
- Engagement of AOD Treatment. Initiation of AOD treatment and two or more additional AOD services or medication treatment within 34 days of the initiation visit.

Denominator Statement

Patients age 13 years of age and older as of December 31 of the measurement year who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and a half months of the measurement year (e.g., January 1–November 15).

Denominator Exclusions

Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List, Medication Treatment for Opioid Abuse or Dependence Medications List) during the 60 days (two months) before the IESD.

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Percentage of Eligibles Who Received Preventive Dental Services

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 1334, Measure Steward: The Child and Adolescent Health Measurement Initiative

Brief Description of Measure

Percentage of individuals ages 1–20 who are enrolled in NC Medicaid or CHIP Medicaid expansion programs for at least 90 continuous days, are eligible for EPSDT services, and who received at least one preventive dental service during the reporting period.

Numerator Statement

The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000–D1999 (or equivalent CDT codes D1000–D1999 or equivalent CPT codes, that is, only those CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid or denied claim.

The numerator should be inclusive of services reimbursed directly by the state under fee-for-service, managed care, prospective payment, or any other payment arrangements, or through any other health or dental plans that contract with the state to provide services to NC Medicaid or CHIP Medicaid expansion beneficiaries, based on an unduplicated paid, unpaid or denied claim

Denominator Statement

The total unduplicated number of individuals ages 1–20 who have been continuously enrolled in NC Medicaid or CHIP Medicaid expansion programs for at least 90 days and are eligible to receive EPSDT services.

Denominator Exclusions

Do not include in this count the following groups of individuals:

- Medically needy individuals ages 1–20 if your state does not provide EPSDT services for the medically needy population

- Individuals eligible for NC Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available
- Undocumented aliens who are eligible only for emergency Medicaid services
- Children in separate state CHIP programs
- Groups of individuals ages 1–20 who are eligible only for limited services as part of their NC Medicaid eligibility (for example, pregnancy-related services)

For full specification, please see the Child Core Set Technical Specifications Manual.

Tobacco Use and Help Quitting for Adolescents

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2803, Measure Steward: NCQA

Brief Description of Measure

Percentage of adolescents 12–20 years of age during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.

Numerator Statement

Adolescents who are not smokers OR adolescents who are smokers but are receiving cessation counseling.

Denominator Statement

Adolescents who turn 12 through 20 years of age during the measurement year.

Denominator Exclusions

None.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the three rates)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0024, Measure Steward: NCQA

Brief Description of Measure

Percentage of patients 3–17 years of age who had an outpatient visit with a primary care physician (PCP) or OB-GYN and had evidence of the following during the measurement year:

- Body mass index (BMI) percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Numerator Statement

Patients who had evidence of the following during the measurement year: a BMI percentile documentation, counseling for nutrition, counseling for physical activity.

Denominator Statement

Patients 3–17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN during the measurement year.

Denominator Exclusions

The measure excludes female patients who have a diagnosis of pregnancy and patients who use hospice services during the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Adult Measures

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1879, Measure Steward: CMS

Brief Description of Measure

Percentage of individuals at least 18 years of age at the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

Numerator Statement

Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

Denominator Statement

Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

Denominator Exclusions

Individuals with any diagnosis of dementia during the measurement period.

Adherence to Statin Therapy for Individuals with Coronary Heart Disease

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0543, Measure Steward: CMS

Brief Description of Measure

The percentage of individuals with cardiovascular disease (CVD), including coronary artery disease, cerebrovascular disease and peripheral artery disease presumed to be of atherosclerotic origin, who are prescribed statin therapy that had a Proportion of Days Covered (PDC) for statin medications of at least 0.8 during the measurement period (12 consecutive months).

Numerator Statement

Individuals with CVD who had at least two prescription drug claims for statins and have a PDC for statin medications of at least 0.8.

Denominator Statement

Individuals at least 21 years of age at the beginning of the measurement period with CVD (including coronary artery disease, cerebrovascular disease and peripheral artery disease presumed to be of atherosclerotic origin) and at least two claims for statins during the measurement period (12 consecutive months).

Denominator Exclusions

None.

Adult BMI Assessment

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0023, Measure Steward: City of New York Department of Health and Mental Hygiene

Brief Description of Measure

Percentage of adults 18 years old or older with valid BMI documentation in the past 24 months.

Numerator Statement

Adults 18 years old or older with BMI documented in the past 24 months.

Denominator Statement

Total number of patients 18 years old or older seen in the measurement period.

Denominator Exclusions

Providers can exclude patients based on medical reason, patient reason or systemic reason.

Asthma Medication Ratio

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1800, Measure Steward: NCQA

Brief Description of Measure

The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Numerator Statement

The number of patients with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Denominator Statement

All patients 5–64 years of age as of December 31 of the measurement year who have persistent asthma and met at least one of the following criteria during both the measurement year and the year prior to the measurement year:

- At least one ED visit with asthma as the principal diagnosis.
- At least one acute inpatient encounter or discharge with asthma as the principal diagnosis.
- At least four outpatient visits, observation visits, telephone visits or online assessments on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events for any controller medication or reliever medication.

Denominator Exclusions

Exclude patients who had any of the following diagnoses any time during the patient's history through the end of the measurement year (i.e., December 31):

- COPD
- Emphysema
- Obstructive chronic bronchitis
- Chronic respiratory conditions due to fumes/vapors
- Cystic Fibrosis
- Acute respiratory failure

Exclude any patients who had no asthma medications (controller or reliever) dispensed during the measurement year.

Exclude patients in hospice.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Avoidable Adult Utilization

Descriptive Information

Measure Type

Rate/Proportion

NQF Number and Measure Steward

NQF# N/A, Measure Steward: AHRQ

Brief Description of Measure

The Department will calculate the following measures of avoidable pediatric hospitalization:

- PQI 01 Diabetes Short-term Complication Admission Rate
- PQI 05 COPD or Asthma in Older Adults Admission Rate
- PQI 08 Heart Failure Admission Rate
- PQI 15 Asthma in Younger Adults Admission Rate

Numerator Statement

Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI 01 Diabetes Short-term Complication Admission Rate
- PQI 05 COPD or Asthma in Older Adults Admission Rate
- PQI 08 Heart Failure Admission Rate
- PQI 15 Asthma in Younger Adults Admission Rate

Denominator Statement

Population ages 18 years and older in a metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or country of residence, not the metropolitan area or county of the hospital where the discharge occurred.

Denominator Exclusions

None.

More information and full specifications are available at

https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2020.aspx

Breast Cancer Screening

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2372, Measure Steward: NCQA

Brief Description of Measure

Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Numerator Statement

Women who received a mammogram to screen for breast cancer.

Denominator Statement

Women 50–74 years of age.

Denominator Exclusions

This measure excludes women with a history of bilateral mastectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan or living long-term in an institution any time during the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)**Descriptive Information****Measure Type**

Outcome: Intermediate Clinical Outcome

NQF Number and Measure Steward

NQF# 0061, Measure Steward: NCQA

Brief Description of Measure

The percentage of patients 18–75 years of age with diabetes (type 1 and 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.

Numerator Statement

Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.

Denominator Statement

Patients 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and 2) during the measurement year or the year prior to the measurement year.

Denominator Exclusions

This measure excludes adults in hospice. It also excludes adults with advanced illness and frailty, as well as Medicare adults 65 years of age and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long-term in institutional settings.

Additionally, exclude patients who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

and who did NOT have a diagnosis of diabetes. These patients are sometimes pulled into the denominator via pharmacy data. They are then removed once no additional diagnosis of diabetes (type 1 or 2) is found.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Comprehensive Diabetes Care: HbA1c Poor Control (<8.0%)

Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

NQF Number and Measure Steward

NQF# 0575, Measure Steward: NCQA

Brief Description of Measure

The percentage of patients 18–75 years of age with diabetes (type 1 and 2) whose most recent HbA1c level is <8.0% during the measurement year.

Numerator Statement

Patients whose most recent HbA1c level is less than 8.0% during the measurement year.

Denominator Statement

Patients 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and 2) during the measurement year or the year prior to the measurement year.

Denominator Exclusions

This measure excludes adults in hospice. It also excludes adults with advanced illness and frailty, as well as Medicare adults 65 years of age and older enrolled in an I-SNP or living long-term in institutional settings.

Additionally, exclude patients who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year and who did NOT have a diagnosis of diabetes. These patients are sometimes pulled into the denominator via pharmacy data. They are then removed once no additional diagnosis of diabetes (type 1 or 2) is found.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Comprehensive Diabetes Care: HbA1c Testing

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0057, Measure Steward: NCQA

Brief Description of Measure

The percentage of patients 18–75 years of age with diabetes (type 1 and 2) who received an HbA1c test during the measurement year.

Numerator Statement

Patients who had an HbA1c test performed during the measurement year.

Denominator Statement

Patients 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or 2) during the measurement year or the year prior to the measurement year.

Denominator Exclusions

Exclude patients who use hospice services or elected to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):

Members who do not have a diagnosis of diabetes in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Comprehensive Diabetes Care: LDL-C Control (100 mg/dL)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 0064, Measure Steward: NCQA

Brief Description of Measure

The percentage of members 18–75 years of age with diabetes (type 1 and 2) whose most recent LDL-C test is <100 mg/dL during the measurement year.

Numerator Statement

Members whose most recent LDL-C test is <100 mg/dL during the measurement year.

Denominator Statement

Members 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or 2) during the measurement year or the year prior to the measurement year.

Denominator Exclusions

Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history but must have occurred by the end of the measurement year.

Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year but must have occurred by the end of the measurement year.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Comprehensive Diabetes Care: LDL-C Screening

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0063, Measure Steward: NCQA

Brief Description of Measure

The percentage of members 18–75 years of age with diabetes (type 1 and 2) who received an LDL-C test during the measurement year.

Numerator Statement

Members 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or 2) during the measurement year or the year prior to the measurement year.

Denominator Statement

Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history but must have occurred by the end of the measurement year.

Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year but must have occurred by the end of the measurement year.

Denominator Exclusions

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 2607, Measure Steward: NCQA

Brief Description of Measure

The percentage of patients 18–75 years of age with a serious mental illness and diabetes (type 1 and 2) whose most recent HbA1c level during the measurement year is >9.0%.

Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF# 0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA.

Numerator Statement

Patients whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year.

The intermediate outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness

and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.

Denominator Statement

Patients 18–75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and 2) during the measurement year or the year before.

Denominator Exclusions

Patients who do not have a diagnosis of diabetes and meet one of the following criteria are excluded from the measure:

- Patients with a diagnosis of polycystic ovaries.
- Patients with gestational or steroid-induced diabetes.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Diabetes and Medication Possession Ratio for Statin Therapy

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0547, Measure Steward: CMS

Brief Description of Measure

Medication Possession Ratio (MPR) for statin therapy in individuals with diabetes over 18 years of age.

Numerator Statement

The sum of the days' supply that falls within the measurement window for a statin fill for each patient in the denominator. Time window is any time during the measurement period (12 consecutive months).

MPR Numerator

New users or patients with no prescriptions in the 180 days prior to the measurement period, the sum of days' supply of all medications from the first prescription until the end of the measurement period.

****Remove the days' supply that extends past the end of the measurement period.**

Continuous users or patients with one or more prescriptions in the 180 days prior to the measurement period, the sum of days' supply of all medications in the measurement period.

****Remove the days' supply that extends past the end of the measurement period and add days' supply from the previous period that apply to the current period.**

Denominator Statement

Patients 18–85 years of age with diabetes mellitus and at least one Part D claim for a statin.
MPR Denominator:

- New users the number of days from the first prescription to the end of measurement period.
- Continuous users the number of days from the beginning to the end of the measurement period.

Time window: Anytime during the measurement period (12 consecutive months).

Denominator Exclusions

- Patients who died during the measurement period.
- Patients who are actively enrolled in multiple plans concurrently as of the end of the measurement period.
- Patients with a diagnosis of polycystic ovaries who did not have a face-to-face visit with a diagnosis of diabetes in any setting during the measurement period (if medical claims (Part A/B data) are available).
- Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who did not have a face-to-face visit with a diagnosis of diabetes in any setting during the measurement period (if medical claims (Part A/B data) are available).

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 3488, Measure Steward: NCQA

Brief Description of Measure

The percentage of ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

- The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).

Numerator Statement

The numerator consists of two rates:

- 30-day follow-up. A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.
- Seven-day follow-up. A follow-up visit with any practitioner, with a principal diagnosis of AOD within seven days after the ED visit (eight total days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13–17, 18 and older, total).

Denominator Statement

ED visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

Denominator Exclusions

Patients in hospice.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2605, Measure Steward: NCQA

Brief Description of Measure

The percentage of discharges for patients 18 years of age and older who had a visit to the ED with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within seven and 30 days of discharge.

Four rates are reported:

- The percentage of ED visits for mental health for which the patient received follow-up within seven days of discharge.
- The percentage of ED visits for mental health for which the patient received follow-up within 30 days of discharge.
- The percentage of ED visits for alcohol or other drug dependence for which the patient received follow-up within seven days of discharge.
- The percentage of ED visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.

Numerator Statement

The numerator for each denominator population consists of two rates:

Mental Health

- Rate 1 - An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within seven days after ED discharge
- Rate 2 - An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after ED discharge

Alcohol or Other Drug Dependence

- Rate 1 - An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within seven days after ED discharge
- Rate 2- An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after ED discharge

Denominator Statement

Patients who were treated and discharged from an ED with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.

Denominator Exclusions

If the discharge is followed by readmission or direct transfer to an ED for a principal diagnosis of mental health or alcohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the ED to which the patient was transferred.

Exclude discharges followed by admission or direct transfer to an acute or non-acute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission.

These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

HIV Viral Load Suppression

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 3210/3210e, Measure Steward: HIV/AIDS Bureau

Brief Description of Measure

Percentage of patients, regardless of age, with a diagnosis of HIV with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Numerator Statement

Patients with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. The outcome being measured is HIV viral suppression.

Denominator Statement

Patients, regardless of age, diagnosed with HIV during the first three months of the measurement year or prior to the measurement year who had at least one medical visit in the measurement year. The target population for this measure is all people living with HIV.

Denominator Exclusions

None.

Pharmacotherapy Management of COPD Exacerbation

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2856, Measure Steward: NCQA

Brief Description of Measure

This measure assesses the percentage of COPD exacerbations for patients 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Numerator Statement

- Numerator #1 (Systemic corticosteroids). The number of patients dispensed a prescription for a systemic corticosteroid on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date.
- Numerator #2 (Bronchodilators). The number of patients dispensed a prescription for a bronchodilator on or 30 days after the Episode Date. Count bronchodilators that are active on the relevant date.

*The Episode Date is the date of service for any acute inpatient discharge or ED claim/encounter during the 11-month intake period with a principal diagnosis of COPD.

Denominator Statement

All patients age 40 years or older as of January 1 of the measurement year with a COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.

Denominator Exclusions

This measure excludes patients who use hospice services and patients with non-acute inpatient stays.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Preventive Care and Screening for Tobacco Use. Screening and Cessation Intervention

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0028, Measure Steward: PCPI Foundation

Brief Description of Measure

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported:

- Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months
- Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention
- Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Numerator Statement

- Population 1 is patients who were screened for tobacco use at least once within 24 months.
- Population 2 is patients who received tobacco cessation intervention.
- Population 3 is patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Denominator Statement

- Population 1 is all patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.
- Population 2 is all patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user.
- Population 3 is all patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.

Denominator Exclusions

Denominator Exclusions: Not applicable.

Denominator Exceptions:

Population 1 is documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason).

Population 2 is documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason).

Population 3 is documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason).

Substance Use Screening and Intervention Composite

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2597, Measure Steward: CMS

Brief Description of Measure

Percentage of patients age 18 years and older who were screened once within the past 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, illegal drug use AND who received an intervention for all positive screening results.

Numerator Statement

Patients who received the following substance use screenings once within the past 24 months AND who received an intervention for all positive screening results:

- Tobacco use component patients who were screened for tobacco use at least once within the past 24 months AND who received tobacco cessation intervention if identified as a tobacco user.
- Unhealthy alcohol use component patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the past 24 months AND who received brief counseling if identified as an unhealthy alcohol user.
- Drug use component (nonmedical prescription drug use and illicit drug use) patients who were screened for nonmedical prescription drug use and illicit drug use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user.

Denominator Statement

All patients age 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12-month measurement period.

Denominator Exclusions

Documentation of medical reason(s) for not screening for substance use (e.g., limited life expectancy, other medical reasons).

Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2600, Measure Steward: NCQA

Brief Description of Measure

The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported.

1. Rate 1 is the percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user.
2. Rate 2 is the percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user.

Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention NQF# 0028). This measure is currently stewarded by the AMA-PCPI and used in the Physician Quality Reporting System.

Numerator Statement

- Rate 1 is screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.
- Rate 2 is screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.

Denominator Statement

- Rate 1 is all patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.
- Rate 2 is all patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.

Denominator Exclusions

None.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

Maternal Measures

Contraceptive Care: Access to Long-Acting Reversible Methods of Contraception (LARC)

Descriptive Information

Measure Type

Structure

NQF Number and Measure Steward

NQF# 2904, Measure Steward: U.S. Office of Population Affairs

Brief Description of Measure

Percentage of women aged 15–44 years at risk of unintended pregnancy who are provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS)).

This is an access measure because it is intended to identify situations in which women do not have access to LARC, i.e., contraceptive implants and intrauterine devices.

Numerator Statement

Women aged 15–44 years at risk of unintended pregnancy who were provided a LARC, i.e., intrauterine device or implant.

Denominator Statement

All women aged 15–44 years who are at risk of unintended pregnancy.

Denominator Exclusions

The following categories of women are excluded from the denominator:

- Those who are infecund for non-contraceptive reasons.
- Women who had a live birth in the last two months of the measurement year.
- Women were still pregnant, or their pregnancy outcome was unknown at the end of the year.

Contraceptive Care: Most and Moderately Effective Methods

Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

NQF Number and Measure Steward

NQF# 2903, Measure Steward: U.S. Office of Population Affairs

Brief Description of Measure

The percentage of women aged 15–44 years at risk of unintended pregnancy who are provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring or diaphragm) method of contraception.

The proposed measure is an intermediate outcome measure as it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.

Numerator Statement

Women aged 15–44 years at risk of unintended pregnancy who are provided a most (sterilization, intrauterine device, implant) or moderately (pill, patch, ring, injectable, diaphragm) effective method of contraception.

Denominator Statement

Women aged 15–44 years who are at risk of unintended pregnancy.

Denominator Exclusions

The following categories of women are excluded from the denominator:

- Those who are infecund for non-contraceptive reasons.
- Those who had a live birth in the last two months of the measurement year.
- Those who were still pregnant, or their pregnancy outcome was unknown at the end of the year.

Contraceptive Care: Postpartum

Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

NQF Number and Measure Steward

NQF# 2902, Measure Steward: U.S. Office of Population Affairs

Brief Description of Measure

Among women ages 15–44 who had a live birth, the percentage that is provided:

- A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring or diaphragm) effective method of contraception within three and 60 days of delivery.
- A LARC within three and 60 days of delivery. Two time periods are proposed (i.e., within three and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the six-week postpartum visit. The three-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care.

Numerator Statement

The primary measure is women ages 15–44 who had a live birth and were provided a most (sterilization, intrauterine device, implant) or moderately (pill, patch, ring, injectable, diaphragm) effective method of contraception within three and 60 days of delivery.

The sub-measure is women ages 15–44 who had a live birth and were provided a LARC within three and 60 days of delivery.

Denominator Statement

Women ages 15–44 who had a live birth in a 12-month measurement year.

Denominator Exclusions

The following categories are excluded from the denominator:

- Deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth or induced abortion).
- Deliveries that occurred during the last two months of the measurement year.

Live Births Weighing Less Than 2500 Grams

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 1382, Measure Steward: CDC

Brief Description of Measure

The percentage of births with birth weight <2,500 grams.

Numerator Statement

The number of babies born weighing <2,500 grams at birth in the study population.

Denominator Statement

All births in the study population.

Denominator Exclusions

None.

Prenatal Depression Screening and Follow-Up

Descriptive Information

Measure Type

NQF Number and Measure Steward

NQF# N/A, Measure Steward: NCQA

Brief Description of Measure

The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported.

- Depression screening defined as the percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.
- Follow-up on positive screen is the percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

For full measure specification, please refer to the HEDIS® Measurement Year 2020 & Measurement Year 2021 Volume 2 Technical Specifications for Health Plans.

CAHPS Survey

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 0006; Measure Steward: AHRQ

Brief Description of Measure

The CAHPS Health Plan Survey is a standardized survey instrument that asks enrollees to report on their experiences accessing care and health plan information and the quality of care received by physicians.³¹

The survey's target population includes individuals of all ages (18 and older for the adult version and parents or guardians of children aged 0–17 for the child version) who have been enrolled in a health plan for a specified period of time (six months or longer for NC Medicaid version, 12 months or longer for commercial version) with no more than one 30-day break in enrollment.

The CAHPS Adult Health Plan Survey has 39 items, and the CAHPS Child Health Plan Survey has 41 core items. Ten of the adult survey items and 11 of the child survey items are organized into four composite measures. Each survey also has four single-item rating measures. Each measure is used to assess a particular domain of health plan and care quality from the patient's perspective.

The Department will include the following CAHPS measures:

- Getting Needed Care
- Getting Care Quickly
- Health Plan Information and Customer Service
- How People Rated Their Personal Doctor
- How People Rated Their Specialist
- How People Rated Their Health Care
- How People Rated Their Health Plan

³¹ The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at <https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html>